

PROFESSIONAL PEER REVIEW AND THE ANTITRUST LAWS

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Professor Havighurst exhaustively explores the antitrust implications of fee, utilization, and quality-oriented peer review. He places such activity first in a theoretical context and then in an historical context that shows why peer review merits particular antitrust attention. He suggests that defending peer review on the same public-interest grounds as are used in defense of the actions of public regulatory bodies is conceptually mistaken. A more appropriate defense, he says, would be that properly conducted peer review—which eschews coercion, performs an advisory function, and leaves to others the decision whether to act on its advice—actually enhances competition in the consumer’s interest. Contrary to numerous contemporary commentators, he argues that special antitrust exemptions for peer-review bodies are not only unnecessary, but would be counterproductive to the continued evolution of sound antitrust principles. Professor Havighurst addresses the effects of peer review on both its professional sponsors and third parties. He concludes that when it does not adversely affect competition among its sponsors peer-review activity should be subject to only minimal judicial scrutiny. Such a result would reinforce the notion that antitrust law should protect competition, not competitors.

INTRODUCTION

TO PHYSICIANS, PEER review—oversight of the practices of an individual doctor by fellow professionals—exemplifies their professionalism and their “selflessness and devotion to patient care.”¹ Believing that they have a collective responsibility as a profession to maintain the quality and contain the cost of medical care, physicians are understandably resentful when their efforts in these directions are challenged in court. They are particularly offended by antitrust suits, which they perceive as imputing to them a self-interested economic motive in seeking to correct those very shortcomings and excesses for which the profession is so often criticized. Any antitrust threat to peer review thus represents a serious con-

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1. Dolin, *Antitrust Law versus Peer Review*, 313 NEW ENG. J. MED. 1156 (1985).

frontation between traditional professionalism and the policy of promoting competition in the health care marketplace.

This Article seeks to clarify the antitrust issues presented by professional peer review, particularly the activities of organized physicians.² It concludes that, although certain professional traditions are indeed under challenge, peer review has an appropriate place in a competitive market policed by the antitrust laws. The Article views as mostly though not entirely unwarranted the concerns that have recently been expressed about the inhibiting effects of private antitrust suits on professional peer review.³ Although the law is always subject to misuse by plaintiffs and misapplication by courts, the usual antitrust tests, properly applied, impose only reasonable limitations on physicians' collective activities. Thus, there should be no need for special statutory immunities (such as one recently enacted by Congress) or for judge-made doctrinal exceptions designed specifically to facilitate professional peer review. Encrusting the law with special exceptions for privileged groups or special treatment for particular activities is a poor approach precisely because it relieves courts of the necessity to rethink basic antitrust doctrine to make certain that it frustrates only conduct that is truly incompatible with competition and consumer welfare.

I. RELEVANT ANTITRUST PRINCIPLES

For antitrust purposes, the essential feature of medical peer review is that it involves collective action by otherwise independent, competing physicians.⁴ This collaboration may have adverse consequences for competition among the collaborators themselves or for some of their competitors. It may nevertheless be defensible under antitrust principles.

2. For a somewhat narrow definition of peer review for purposes of this Article, see *infra* text accompanying notes 19-26. Although the main topic here is medical peer review, other professionals who engage in independent practice also undertake concerted peer-review activities that raise antitrust questions. See, e.g., *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119 (1982) (chiropractors); *Iowa Dental Ass'n*, 99 F.T.C. 648, 649-50 (1982) (dentists); *United States v. Illinois Podiatry Soc'y*, 1977-2 Trade Cas. (CCH) ¶ 61,767 (N.D. Ill. 1977) (podiatrists). The conclusions reached in this Article are equally applicable to other professionals.

3. See, e.g., AMA, *Insurers Beef up M.D. Discipline Efforts*, Am. Med. News, June 20, 1986, at 2 (physician leaders said to be "insistent . . . that no stepped-up peer review and peer discipline can be accomplished without changes in the law that would protect physicians who perform peer review from lawsuits of recrimination that might be filed by a disgruntled physician"); Dolin, *supra* note 1; Rust, *Peer Review Confidentiality Key Issue in Lawsuit*, Am. Med. News, Oct. 25, 1985, at 1.

4. But see *infra* note 24.

When competitors collaborate, section 1 of the Sherman Act asks, in essence, whether their concerted action is compatible with the maintenance of a competitive market as a vehicle to promote consumer welfare.⁵ Collaboration between competitors is procompetitive when it manifests an impulse to compete, such as where a joint venture is formed to achieve efficiencies in production and distribution or where it provides an altogether new product or service. In other cases, competitors may permissibly combine in order to make competition more effective by rectifying some defect in the market's operation—as where they organize an auction market⁶ or collect and disseminate information useful to themselves or to consumers.⁷

Accomplishment of these various procompetitive objectives does not require that the collaborating parties be collectively powerful enough to affect competition by raising prices, depressing output, or preventing innovation. In those cases where possession of market power is essential before a joint venture can accomplish its professed objectives, the venture is almost certainly unlawful, because it constitutes a naked attempt to prevent the competitive process from operating.⁸ As will be demonstrated, the legal status of professional peer review depends heavily on whether its effect is to regulate—that is, actually control—medical practice in contravention of market forces or is instead only to generate information and advise independent decision makers in a competitive market.

There will be some cases in which, even though the goals of a collaboration are procompetitive, the collective power of the collaborators, crudely measured, is great enough to warrant concern that competition will be jeopardized. In these cases, the collaborators' specific arrangements must be scrutinized to see whether the restraints they impose are reasonable in the limited sense that they are both (1) ancillary to—that is, truly necessary to achieve—the alleged procompetitive objective and (2) crafted to minimize the risk of anticompetitive effects.⁹ Even if a restraint is deemed ancillary and reasonable under these tests some danger to competition may still remain because of the parties' collective power. The court must

5. See 15 U.S.C. § 1 (1982).

6. See, e.g., *Chicago Bd. of Trade v. United States*, 246 U.S. 231 (1918), as narrowly interpreted in *National Soc'y of Professional Engineers v. United States*, 435 U.S. 679, 693 n.19 (1978).

7. See, e.g., *Maple Flooring Mfrs. Ass'n v. United States*, 268 U.S. 563 (1925).

8. See *infra* text accompanying notes 75-83.

9. The best statement of the appropriate tests remains *United States v. Addyston Pipe & Steel Co.*, 85 F. 271, 280-84 (6th Cir. 1898), *aff'd*, 175 U.S. 211 (1899).

then decide whether that danger is outweighed by the potential benefits to consumers and to competition. This balancing can frequently be accomplished with only a "quick look," leading to a blurring of antitrust law's traditional dichotomy between "per se" violations and conduct requiring extensive examination under the "Rule of Reason."¹⁰

This brief exposition of antitrust theory¹¹ leads to two observations that are particularly relevant to the discussion of professional peer review. First, the law leaves virtually no room for defending a restriction on competition by claiming that it was inspired by pure or public-spirited motives.¹² Physicians sued for engaging in peer review cannot simply plead that their purpose was a worthy one. Instead, they must maintain that their actions were not incompatible with the maintenance of effective competition in the larger market for medical services. Even though evidence in antitrust suits frequently focuses on the defendants' motives, motive is ultimately relevant only as a reflection of the likely effect on competition of the challenged practice. Physicians are mistaken in asserting that antitrust suits challenging their collective actions necessarily misconstrue their motives. An antitrust violation may exist even if the motive behind an anticompetitive practice is virtuous in the highest

10. Courts can improve the quality of antitrust rules by going beyond the customary dichotomization between per se prohibitions and a supposedly unitary Rule of Reason that calls for the same level of scrutiny in every case. Recently the Solicitor General has suggested that, in certain Rule of Reason cases, a "quick look" may be all that is required. Brief for the United States as Amicus Curiae in Support of Affirmance at 7-8, *NCAA v. University of Oklahoma*, 104 S. Ct. 2948 (1984); Brief for the United States as Amicus Curiae at 19-20, *Arizona v. Maricopa County Medical Soc'y*, 457 U.S. 332 (1982). Others have advanced the notion of a "truncated" rule of reason. See e.g., Sullivan & Wiley, *Recent Antitrust Developments: Defining the Scope of Exemptions, Expanding Coverage, and Reforming the Rule of Reason*, 27 UCLA L. REV. 265, 330-36, 341-42 (1979).

11. This summary of antitrust doctrine is somewhat more structured and coherent than the analysis typically found in cases and commentary. This analysis focuses first on the collaborators' purpose (and the distinction between naked and ancillary restraints), then on their market power (and the less-restrictive-alternative requirement that is triggered by its presence), and finally on the possible need to balance procompetitive and anticompetitive effects. This analysis dispels two common but conceptually erroneous beliefs: that there is such a thing as a "reasonable" restraint of trade and that the collaborators' intent is the central issue rather than evidence of the probable effect of the collaboration. See generally H. HOVENKAMP, *ECONOMICS AND FEDERAL ANTITRUST LAW* 110-34 (1985); ABA ANTITRUST LAW SECTION, *ANTITRUST LAW DEVELOPMENTS* 2-55 (2d ed. 1984); P. AREEDA, *THE RULE OF REASON IN ANTITRUST ANALYSIS: GENERAL ISSUES* (Federal Judicial Center 1981); E. GELLHORN, *ANTITRUST LAW AND ECONOMICS* 175-257 (3d ed. 1986).

12. See *National Soc'y of Professional Engineers v. United States*, 435 U.S. 679, 693-94 (1978) (rejecting defense that restricting competitive bidding for professional services would ensure public safety). But see *infra* text accompanying notes 73-80.

professional tradition.¹³

It is a regrettable but easily defensible feature of antitrust law that those individual professionals who take their public responsibilities most seriously and selflessly contribute their time and energy to operate a self-regulatory program are the ones exposed to liability if the program is ultimately adjudged to restrain trade. A court may find that the collaborators, despite their good intentions, were operating on a mistaken premise when they interfered with the competitive process. Although a few courts, sensing a benign impulse underlying some professional restraints, have been inclined to excuse them,¹⁴ the safest legal rule for professionals to follow is that the competitive power can never be restrained, even for a worthy purpose.¹⁵

13. See, e.g., *Arizona v. Maricopa County Med. Soc'y*, 457 U.S. 332, 348 (1982) (applying per se rule to maximum fee limits imposed by physicians on themselves); *AMA v. FTC*, 638 F.2d 443, 449-50 (2d Cir. 1980) (upholding FTC invalidation of provisions of professional code of ethics), *aff'd by an equally divided Court*, 445 U.S. 676 (1982).

14. E.g., *United States v. Oregon State Med. Soc'y*, 343 U.S. 326, 336 (1952) (dictum suggesting lawfulness of boycott for ethical objectives); *Indiana Fed'n of Dentists v. FTC*, 745 F.2d 1124, 1136 (7th Cir. 1984) (dentists' agreement in restraint of trade excused as protecting professional values), *rev'd*, 106 S. Ct. 225 (1986); *Wilk v. AMA*, 719 F.2d 207, 221-22, 226-27 (7th Cir. 1983) (allowing association to justify boycott of competitors by reference to patient-care concerns), *cert. denied*, 467 U.S. 1210 (1984).

15. It is doubtful that lawyers counselling professional clients are relying on the view that professional services are special and therefore subject to "soft" antitrust rules. See *infra* note 36. Even if the competitive market is deemed to perform poorly in some respect, there is no solid legal ground for absolving professional actions that interfere with its operation. See Havighurst & Hackbarth, *Enforcing the Rules of Free Enterprise in an Imperfect Market: The Case of Individual Practice Associations*, in *A NEW APPROACH TO THE ECONOMICS OF HEALTH CARE* 377 (M. Olson ed. 1982). For the suggestion that minor restraints correcting "market failures" might be permissible, see *infra* text accompanying notes 75-83.

One justification for maintaining rigorous antitrust rules that do not bend for good intentions or public-interest claims is the desirability of maintaining a strong deterrent to violations; effective deterrence requires a bright line denying competitors pretexts that might tempt them to impair socially desirable competition in the hope that their claim of a worthy purpose will shield them from at least the most severe penalties. See, e.g., *Northern Pac. Ry. v. United States*, 356 U.S. 1, 5 (1958) (articulating basic rationale for bright line, per se rules of illegality in antitrust law); *Arizona v. Maricopa County Med. Soc'y*, 457 U.S. 332, 343-48 (1982) (delineating virtues of clear rules). Another argument for a rigorous and certain rule is the inappropriateness of letting "the vague and varying opinion of judges . . . [determine] how much, on principles of political economy, men ought to be allowed to restrain competition." *United States v. Addyston Pipe & Steel Co.*, 85 F. 271, 283-84 (6th Cir. 1898), *aff'd*, 175 U.S. 211 (1899).

Although restraints of trade should not be tolerated simply on the ground that they serve the general public interest, the law must leave room for concerted action that is procompetitive. Unfortunately, some Supreme Court opinions have suggested that courts are helpless, under precedents creating per se violations, to distinguish procompetitive from anticompetitive collaboration and may sometimes be compelled to condemn useful activity. E.g., *Arizona v. Maricopa County Med. Soc'y*, 457 U.S. 332, 348-55 (1982) (discussed *infra* note 70

The second observation that is prompted by the formulation of antitrust doctrine offered above is that the fate of individual competitors is not a primary legal concern of antitrust law. Although litigation against a peer-review body is most likely to be initiated by an injured physician, the appropriate concern is with effects on "competition, not competitors."¹⁶ If a practice impairs competition to the presumed detriment of consumers, a victim of that practice may have standing¹⁷ to recover treble damages. But harm to that individual is not harm to competition itself. Competition specifically contemplates that some competitors will lose while others prosper, and courts' insistence on fair dealing by competitors vis-à-vis one another could itself easily reduce the vigor of competition and harm consumer welfare.¹⁸ In the final analysis, the true object of the Sherman Act is to protect the competitive process. It should not penalize competitor collaboration unless that process is impaired.

Professional peer review constitutes concerted action by competitors and is subject to antitrust scrutiny. Because it has an important impact on other competitors, it is likely to result in antitrust

and accompanying text); *Topco Ass'ns. v. United States*, 405 U.S. 596, 608-12 (1972). *But see* *Rothery Storage & Van Co. v. Atlas Van Lines, Inc.*, No. 84-5845, slip op. (D.C. Cir. June 3, 1986) (opinion by Bork, J., applying rule of reason to market division by joint venturers). Even if courts seeking the clarity of per se rules have tied their own hands to some extent, there should be no obstacle to intelligent application of the law to peer review, which does not fall within any of the categories of conduct traditionally treated by the courts as per se offenses. For a recent attempt to overcome antitrust law's difficulty in dealing sensibly with peer-review efforts in the hospital setting, see Havighurst, *Doctors and Hospitals: An Antitrust Perspective on Traditional Relationships*, 1984 DUKE L.J. 1071.

16. *Brunswick Corp. v. Pueblo Bowl-O-Mat, Inc.*, 429 U.S. 477, 488 (1977). *See also* *Continental T.V., Inc. v. G.T.E. Sylvania Inc.*, 433 U.S. 36, 51-52 (1977) (refocusing law of vertical restraints more on harm to competition than on freedom of dealers).

17. On the law of standing in antitrust cases, see generally H. HOVENKAMP, *supra* note 11, at 356-66; Berger & Bernstein, *An Analytical Framework for Antitrust Standing*, 86 YALE L.J. 809 (1977).

18. Antitrust law does not specifically require that competitors must behave fairly toward one another, but fairness is sometimes insisted upon by courts as a way of protecting against injury to competition. *See, e.g.,* *Silver v. New York Stock Exchange*, 373 U.S. 341, 349 (1962) (discussed *infra* text accompanying note 97). Antitrust law appears to be moving from seeking to enforce fairness in business dealings between large and small firms—at some expense to efficiency—into an era in which the dominant concern is consumer welfare, as served by efficiency in production and by hard—as opposed to judicially-inhibited—bargaining and competition. The debate concerning the transition is extensive and ongoing. *See, e.g.,* R. BORK, *THE ANTITRUST PARADOX* (1978); R. POSNER, *ANTITRUST LAW: AN ECONOMIC PERSPECTIVE* (1976); Kissam, *Antitrust Boycott Doctrine*, 69 IOWA L. REV. 1165 (1984) (arguing for stressing fairness); Symposium, *Antitrust Law and Economics*, 127 U. PA. L. REV. 918 (1979); *Antitrust Jurisprudence: A Symposium on the Economic, Political and Social Goals of Antitrust Policy*, 125 U. PA. L. REV. 1182 (1977); Sullivan, *Book Review*, 75 COLUM. L. REV. 1214 (1975).

lawsuits. But whether peer review is procompetitive or anticompetitive cannot be determined until more is known about how it operates.

II. PEER REVIEW IN ACTION

Peer review encompasses a wide range of professional activities, including the informal, collegial oversight and interaction that occur within medical group practices and hospital medical staffs.¹⁹ At the other extreme, there are communitywide peer-review bodies, including foundations for medical care, which review claims for private insurers,²⁰ and Peer Review Organizations (PROs), which are formed pursuant to federal law primarily to review care provided to Medicare beneficiaries but which also provide peer-review services to private payors.²¹

This Article, in addressing antitrust issues, focuses specifically on those peer-review bodies that are controlled by or operate on behalf of a substantial percentage of the physicians in a community and concern themselves with care rendered and paid for in the private sector. Because of this limited focus, the Article has little to say about group practices or hospital medical staffs.²² It also does not consider the Medicare-related activities of PROs and their forerunners, Professional Standards Review Organizations (PSROs).²³

19. For an extensive evaluation of the hospital medical staff, see Havighurst, *supra* note 15, at 1092-97, 1101-42.

20. See, e.g., *Arizona v. Maricopa County Med. Soc'y*, 457 U.S. 332, 339-42 (1982) (describing two such organizations); C. STEINWALD, AN INTRODUCTION TO FOUNDATIONS FOR MEDICAL CARE (1971); Egdaahl, *Foundations for Medical Care*, 288 NEW ENG. J. MED. 491 (1973).

21. Peer Review Improvement Act of 1982, Pub. L. No. 97-248, § 143, 96 Stat. 382, 385, 387 (codified at 42 U.S.C. § 1302c-3 (1982)). The statute requires that a PRO contracting with the federal government must "make available its facilities and resources for contracting with private and public entities paying for health care in its area for review, as feasible and appropriate, of services reimbursed by such entities." 42 U.S.C. § 1320c-3(a)(11) (1982). See also *infra* note 25; see generally Webber & Goldbeck, *Utilization Review*, in SYNTHESIS OF PRIVATE SECTOR HEALTH CARE INITIATIVES ch. 4 (Office of the Asst. Sec'y for Planning and Evaluation, DHHS, March 1984); Hastings, *Legal Issues Raised by Private Review Activities of Medical Peer-Review Organizations*, 8 J. HEALTH POL., POL'Y & LAW 293 (1983).

22. It is intended to exclude from consideration, among other things, those physician-controlled entities that function within a larger competing entity, such as a hospital (see Havighurst, *supra* note 15), or that are themselves entities competing against other physicians in the community, such as a group practice or preferred-provider organization. Such organizations may present difficult antitrust issues, but they are distinct from those related to peer review itself. See *infra* note 87.

23. Regarding PSROs, see generally CONGRESSIONAL BUDGET OFFICE, *The Impact of PSROs on Health-Care Costs: Update of CBO's 1979 Evaluation* (1981); Smits, *The PSRO in*

As long as these latter entities merely review claims under public programs pursuant to a congressional mandate, they are not subject to the antitrust laws because such laws do not preclude the federal government from administering its own programs. In contrast, PROs that are sponsored by professional interests²⁴ and undertake to review privately financed care appear to enjoy no implied exemption from antitrust scrutiny, despite their statutory obligation to make their "facilities and resources" available to private payors.²⁵

Perspective, 305 NEW ENG. J. MED. 253 (1981); Havighurst & Blumstein, *Coping with Quality/Cost Trade-offs in Medical Care: The Role of PSROs*, 70 NW. U.L. REV. 6, 38-60 (1975).

24. Whether a particular PRO should be viewed as a powerful combination of competitors or as a simple joint venture competing to provide claims-review services to public and private payors could easily become a matter of dispute. Under the PRO legislation, two types of organizations are given a special preference in seeking PRO designation. One of these types, a "physician-sponsored organization," is defined in regulations as one composed of at least 10% of the area's licensed practicing physicians. See 42 C.F.R. § 462.102(b) (1985). The AMA sought to obtain a preference for organizations representing at least 25% of the area's physicians (as under the earlier PSRO law). See Editorial, *Proposed Regulations on PROs Raise Concerns*, Am. Med. News, Oct. 7, 1983, at 3. Although the action of the Health Care Financing Administration in setting the lower percentage test for physician sponsorship may have somewhat attenuated the connection between such PROs and organized medicine, the cited regulations also require that a physician-sponsored PRO must be "representative" of area physicians. Moreover, a physician-sponsored PRO is generally understood to be one that enjoys sponsorship of the profession as a whole. Finally, because the Peer Review Improvement Act provides that a financial intermediary, such as a Blue Cross plan, could be designated as the area PRO if a physician-sponsored group could not be identified within six months, state medical societies had a strong incentive to organize a PRO of their own. Of the first 19 PRO contracts awarded, 15 went to groups organized with medical society support. Only in Idaho has a financial intermediary received a PRO contract.

There are of course other, community-based peer-review bodies that are directly and obviously sponsored by the medical establishment and thus more clearly present the risks that prompt antitrust scrutiny. See generally C. STEINWALD, *supra* note 20; Egdahl, *supra* note 20.

25. Because of the large responsibilities assigned PROs under the Medicare program, most discussion of professional peer review focuses primarily on its role with respect to publicly financed care. See, e.g., K. LOHR, *PEER REVIEW ORGANIZATIONS: QUALITY ASSURANCE IN MEDICARE* (Rand Corp. 1985); Dans, Weiner & Otter, *Peer Review Organizations: Promises and Potential Pitfalls*, 313 NEW ENG. J. MED. 1131 (1985). It is easy to assume that peer review of privately financed care is such a natural extension of the concept embodied in the Medicare program that no legal or other distinction should be drawn. It appears, however, that the PRO legislation, which invites, and thus implicitly exempts, PRO activities affecting public programs from the antitrust laws, provides no comparable immunity for PROs participating in private review. Despite the argument that such private review activities are expressly mandated by federal law (see *supra* note 21), the statute says only that a PRO must make its "facilities and resources" available to the private sector. Thus, it contemplates that private payors will delegate to PROs only the administrative task of applying the payor's own standards to particular cases, not the more crucial responsibility of establishing the standards themselves. Indeed, the legislation seems to have been carefully crafted to ensure only that PROs, with their elaborate review mechanisms in place in each community, would be available to help private insurers, which often lack the capacity to deal with providers on the spot, apply their own criteria for payment. This legislative scheme leaves PROs

Another type of professional activity that is excluded from consideration as peer review in this Article is the scrutiny of individual practitioners that is undertaken by a local medical society or other professional organization to determine their eligibility for organization membership. In addition to peer approval, nearly all such professional organizations confer significant social and professional benefits and advantages on their members. When these latter, possibly unique benefits are specifically tied to compliance with the organization's membership standards, the organization becomes more than a mere credentialing or peer-review body and may be, for antitrust purposes, a horizontal combination of competitors who have nakedly agreed, through the setting of standards, to compete only in specific ways.²⁶ Because this Article's focus is on collective professional actions that yield only authoritative information, judgments, and advice for use by independent decision makers, professional or-

that have preempted the role of setting payment policies for private payors open to possible challenge (though not necessarily to liability) under the legal principles developed in later discussion. Thus, Congress did not contemplate that PROs would necessarily perform for private payors the same coverage-definition functions that PSROs performed for the Medicare program under passive cost reimbursement. See *infra* notes 34, 52 and accompanying text.

The argument was once made that professional organizations providing administrative assistance to private health insurers were entitled to the antitrust exemption for "the business of insurance" under the McCarran-Ferguson Act, 15 U.S.C. § 1011-15 (1982). This argument was rejected in *Union Labor Life Ins., Co. v. Pireno*, 458 U.S. 119 (1982). It seems clear that that exemption should not extend to restraints occurring in markets for insured services. See Crump & Maxwell, *Health Care, Cost Containment, and the Antitrust Laws: A Legal and Economic Analysis of the Pireno Case*, 56 S. CAL. L. REV. 913 (1983); Borsody & Tiano, *Peer Review and the Antitrust Laws: An Analysis and a Proposal*, 26 ST. LOUIS U.L.J. 511, 517-23 (1982); Note, *Antitrust Implications of Chiropractic Peer Review Committees*, 8 AM. J. L. & MED. 45, 50-57 (1982).

26. The author has addressed the legal issues surrounding membership policies of professional societies in the context of private credentialing. See Havighurst & King, *Private Credentialing of Health Care Personnel: An Antitrust Perspective* (pt. 1), 9 AM. J. L. & MED. 131, 150-84 (1983). That discussion specifically observes "the risk that a professional association could parlay the tangible advantages of membership into a system for controlling the competitive behavior of a large number of physicians." *Id.* at 172. In discussing an orthodontist society's exclusion of a dentist for delegating tasks to a licensed but uncertified practitioner, the article suggested that, "although such a membership criterion might seem related to a professional objective of ensuring the quality of care, the implied agreement among members to forswear one form of lawful competition and to boycott nonmembers would undoubtedly be held to violate the antitrust laws today." *Id.* at 167 (discussing *Pinsker v. Pacific Coast Society of Orthodontists*, 12 Cal. 3d 541, 526 P.2d 253, 116 Cal. Rptr. 245 (1974)). For a statute treating professional society membership determinations as peer review, see the Health Care Quality Improvement Act of 1986, Pub. L. No. 99-660, __ Stat. __ (1986). This legislation carries some risk that it will immunize professional organizations against private damage suits alleging not just that a member was excluded to eliminate him as a competitor but that he was disciplined pursuant to an unlawful horizontal agreement limiting competition among the society's members. See *infra* text accompanying notes 126-31.

ganizations that directly enforce their judgments are not considered to be engaged, strictly speaking, in peer review. The reasons for the distinction thus drawn will become increasingly clear.

Communitywide physician peer-review organizations review private transactions for different purposes, each of which raises different antitrust issues. One common function of peer-review bodies has been to determine the reasonableness of fees charged by individual professionals for particular insured services. This activity is occasioned by the practice of many health insurers of paying whatever amount a physician elects to charge, so long as it does not exceed a "usual, customary, and reasonable" (UCR) fee.²⁷ The medical profession has offered peer-review committees to insurers to resolve disputes that arise with respect to particular bills under the UCR approach to physician compensation. Because these committees concern themselves with the price of services, antitrust questions naturally arise. To the extent that professional fee review is only retrospective and advisory, however, any antitrust problems it presents are distinguishable from those that justify the usual per se condemnation of naked price-fixing agreements.²⁸

Utilization review is another function of peer review. This activity, which is often combined with fee review, focuses on the necessity and appropriateness of particular medical services. Private health insurance policies typically commit the insurer to pay only for services that are "medically necessary."²⁹ Many insurers have subscribed to professional peer review as a mechanism for deciding

27. For a description and defense of this payment method, see Crump & Maxwell, *supra* note 25, at 915-18. See also *infra* note 51 and accompanying text.

28. See *infra* notes 69-72 and accompanying text (discussion of *Arizona v. Maricopa County Med. Soc'y*, 457 U.S. 332 (1982)). See also cases cited *infra* note 86. For a discussion of profession-sponsored relative value scales used in setting medical fees, see Havighurst & Kissam, *The Antitrust Implications of Relative Value Studies in Medicine*, 4 J. HEALTH POL., POL'Y & L. 48 (1979). Numerous consent decrees have invalidated relative value scales. But see *United States v. American Soc'y of Anesthesiologists*, 473 F. Supp. 147, 160-61 (S.D.N.Y. 1979) (refusing to condemn relative value guides as per se violations). See also Pfizenmayer, *Antitrust Law and Collective Physician Negotiations with Third Parties: The Relative Value Guide Object Lesson*, 7 J. HEALTH POL., POL'Y & L. 128 (1982) (offering countervailing power defense for collective actions stopping short of overt price fixing). In *Goldfarb v. Virginia State Bar*, 421 U.S. 773, 781 (1975), the Supreme Court said that if the lawyers' minimum fee schedule in that case had been "purely advisory," a "different question" would have been presented.

29. See, e.g., *Union Labor Life Ins., Co. v. Pireno*, 458 U.S. 119, 122 (1982) (observing how insurer's "policies limit the company's liability to 'the reasonable charges' for 'necessary' medical care and services" (emphasis in original) (citation omitted)). Such policies are typical.

which services meet this contractual criterion.³⁰ Although the antitrust concerns raised by profession-sponsored utilization review are less obvious than the objections to fee determinations, tampering with system output can be as harmful to consumers as tampering with price.³¹ Once again, however, the precise reason for antitrust concern is somewhat unclear.

Yet another focus of professional peer review is the quality of care being provided. Although the rationale for quality review would seem to contrast sharply with the cost-containment objective that motivates review of fees and utilization practices, the two concerns are frequently blended in a single program. Many professionals are more receptive to the idea of quality-oriented peer review than they are to outsiders' questioning of their discretion for the purposes of cost control. As a result, peer-review bodies and their professional sponsors regularly seek to justify their cost-containment efforts as being, in reality, quality-assurance measures. This method of justifying cost containment leads to some semantic confusion,³² but it reflects the widely shared belief that peer-review bodies should balance quality concerns against cost objectives in appraising utilization and the reasonableness of fees. The view that professional bodies are ultimately responsible for reconciling cost considerations and quality claims is firmly rooted in professional tradition. It may, however, offend antitrust policy if private choices are thus preempted.

Although quality is a constant watchword in all profession-

30. See *United Labor Life Ins., Co. v. Pireno*, 458 U.S. 119, 123 (1982) ("In making some of these determinations, ULL has arranged . . . to use the advice of NYSCA's Peer Review Committee."). Large employers have also relied upon professional organizations such as PSROs to review claims under their health insurance programs. See, e.g., *Rhode Island Professional Standards Review Org.*, 101 F.T.C. 1010 (1983) (FTC advisory opinion approving private utilization review for employers); see also *Hearing on Proposed Phaseout of PSROs and Utilization Review Requirements*, before the Subcomm. on Health, Senate Comm. on Finance, 97th Cong., 1st Sess. 84-97 (1984) (testimony of Duane H. Heintz, Deere & Co.); *id.* at 28-29 (statement of Gregory J. Ahart, General Accounting Office); see also *Hearing on PSRO Proposals* before the Subcomm. on Health, Senate Comm. on Finance, 97th Cong., 2d Sess. *passim* (1982) [hereinafter cited as *Hearing on PSRO Proposals*]. Reports of favorable results of such peer-review efforts led Congress to provide for private sector review by PROs. See *supra* note 21.

31. See *infra* note 71.

32. See Havighurst & Blumstein, *supra* note 28, at 45 (noting how, in the early days of implementation of the PSRO program, "quality of care" became something of a 'code word' for professional prerogatives, and 'cost control' was soft-pedaled, having become a 'buzz word' for government interference"); see also Tabak, *PSROs: Mechanisms for Quality Assurance or Cost Containment?*, *Quality Assurance Bull.*, Dec. 1978, at 15. For a thoughtful effort to define quality in light of the cost of achieving it, see A. DONABEDIAN, *THE DEFINITION OF QUALITY AND APPROACHES TO ITS ASSESSMENT* 3-28 (1980).

sponsored peer review, quality assurance is also an independent function of many peer-review programs, which may single out individual practitioners as lacking essential skills or as being neglectful of their patients' welfare. This quality-assurance mission may be carried out for some of the same clients that are served by cost-containment efforts. For example, the quality-oriented peer review that occurs within group practices, hospitals, and HMOs can be best understood as part of the sponsoring entity's effort to improve its performance and to compete with other entities.³³ Similarly, the Medicare program relies upon PROs to ensure that its beneficiaries are not the victims of overeconomizing by providers seeking to profit from the prospective payment system.³⁴ Although private insurers have not been very interested in the quality dimension of the care they underwrite, insurers and employers are likely to see an increasing need—as cost-containment efforts intensify—to assure patients that cost savings are not being achieved at the expense of their health.

Quality-oriented peer review undertaken for specific private clients is easily regarded as procompetitive as long as the client remains ultimately in charge.³⁵ Substantial antitrust problems arise only when the peer-review body purports to function, not for a specific client, but on behalf of the community as a whole. Such peer review, if it is done scrupulously and evenhandedly, may manifest the medical profession's sense of collective responsibility for the welfare of patients whose ignorance of the technical side of medicine may expose them to a real risk of incompetence. Antitrust oversight may still be needed, however, to protect against possible abuse and preemption of consumer choice.

Peer-review bodies are generally barred by antitrust law from imposing direct and explicit sanctions that would enable them to

33. See, e.g., Havighurst, *supra* note 15, at 1029-98, 1126-31 (stating procompetitive arguments for hospital based peer review).

34. Recent changes in the method of paying hospitals under Medicare have dramatically changed the function of professional peer review within the program. Previously, when hospitals were reimbursed for their retrospectively determined costs, peer review was employed to ensure that only needed services were provided and that patients were not hospitalized longer than necessary. With respect to the PSRO program, under which cost containment was a primary objective, see generally Havighurst & Blumstein, *supra* note 23. With the recent shift to payment of prospectively fixed allowances determined by reference to the patient's diagnosis, peer review is now needed to ensure that corners are not cut by hospitals seeking to profit from non-cost-based reimbursement. Regarding the role of PROs under the reformed Medicare, see K. LOHR, *supra* note 25; Dans, Weiner & Otter, *supra* note 25.

35. See Havighurst, *supra* note 15, at 1116-22, 1125-31 (discussing peer review in the hospital setting and emphasizing the need for hospital authority over the medical staff).

enforce quality standards for the entire community. Thus, coercive boycotts of unapproved providers³⁶ and other agreements by which competitors surrender their freedom of action to achieve some common objective are almost certainly unlawful regardless of their arguably worthy purpose.³⁷ Despite their inability to take direct action to maintain quality standards, however, peer reviewers may still exert substantial influence over market outcomes. For instance, their findings of quality deficiencies may be used by public licensing authorities, hospitals, insurers, referring physicians, and patients themselves. As long as these independent actors decide for themselves whether to act on the information and advice provided by the peer reviewers, antitrust law is not obviously offended.

Antitrust actions may nevertheless arise if the peer reviewers are perceived to be part of a larger conspiracy. Moreover, a peer-review body may also be sued on the theory that it is itself an unlawful combination of competitors. The risk of liability may be particularly great if the peer-review body lacks the legitimacy conferred by a vertical relationship with an independent client and appears as an extra-governmental agency exercising powers akin to those of public regulators.³⁸ The antitrust defense for such communitywide quality assurance must be carefully framed if legal risks are to be kept manageable.

36. Boycotts are usually treated as per se violations of the Sherman Act. *See, e.g., Klor's, Inc. v. Broadway-Hale Stores, Inc.*, 359 U.S. 207, 212 (1959) (boycott, concerted refusals to deal by traders); *Fashion Originators' Guild v. FTC*, 312 U.S. 457, 466 (1941) (guild member manufacturers and retailers); *Silver v. New York Stock Exchange*, 373 U.S. 341, 347-49, 360 (1963) (declaring boycotts for self-regulatory purposes per se violation in the absence of special legislation, such as that authorizing stock exchanges to make rules restricting members' dealings with third parties). One court, however, has made a questionable exception for physician boycotts of competitors for "patient-care motives." *Wilk v. AMA*, 719 F.2d 207, 219, 221-22, 226-27 (7th Cir. 1983), *cert. denied*, 467 U.S. 1210 (1984). In addition, in *AMA v. United States*, 130 F.2d 233 (D.C. Cir. 1942), *aff'd*, 317 U.S. 519 (1943), the court of appeals, while finding certain boycotts unlawful, stated that the defendants "were permitted to organize, to establish standards of professional conduct [and] to effect agreements for *self-discipline and control*." *AMA*, 130 F.2d at 248 (emphasis in original). Nevertheless, professionals would be ill-advised to rely on this dictum or the *Wilk* case to justify imposing coercive sanctions. The conceptual difference between taking direct action to exclude a competitor from the market and merely publishing information and opinion is fundamental in antitrust law. *See, e.g., Eastern States Retail Lumber Dealers' Ass'n. v. United States*, 234 U.S. 600, 614 (1914) (retailers circulating list of wholesalers that sold directly to consumers held in violation because of clear intention to boycott).

37. *See infra* text accompanying notes 75-83.

38. On the fundamental significance of the involvement of an independent party standing in a vertical market relationship with the horizontal combination, see Havighurst, *supra* note 15, at 1147-57.

III. CONCEPTUALIZING THE ANTITRUST DEFENSE FOR PEER REVIEW

The actions of peer-review bodies are typically defended, both in policy debates and in the courts, in the same way that the actions of public regulatory agencies are defended—as actions taken in the public interest with due process and the support of substantial evidence. However natural it may be to defend peer review as a regulatory service to the public, an antitrust defense on this ground is conceptually mistaken. Moreover, it exposes the peer reviewers to a greater risk of antitrust liability and to greater litigation costs than they would face under a properly mounted defense.

The best antitrust defense for peer-review efforts is that, far from restraining trade, peer review is entirely consistent with the maintenance of competition and actually helps the competitive process. If they have done their job properly, peer reviewers can maintain that they have merely provided appropriate decisionmakers with information and authoritative advice that they cannot otherwise easily obtain. This argument is most persuasive when the peer reviewers are employed by a particular client who specifically seeks such information and advice. It is also valid, however, when the peer-review body is acting on its own initiative. Of course, the peer reviewers must confine their efforts to collecting and disseminating information for others to use and must not engage in coercive boycotts. As long as peer reviewers do not assume a coercive, regulatory role,³⁹ they can reasonably contend that they have not restrained trade.

Even the provision of biased or inaccurate information by peer reviewers is not, without more, a restraint of trade under any reasonable definition of that phrase. Even though unfairness is possible, the existence of state tort remedies for defamation, unfair competition, insurer bad faith, and interference with private contracts should obviate the invention of a spurious antitrust theory to redress perceived injuries.⁴⁰ For purposes of antitrust restraint-of-trade analysis, providing the consuming public with misleading information or bad advice does not interfere with the independent, decentralized decision making that is the essential characteristic of a competitive market.⁴¹ Moreover, the *Noerr-Pennington* doctrine⁴²

39. See *infra* text accompanying note 47.

40. For discussion of the application of such common-law theories to professional certification and accreditation activities, see Havighurst & King, *supra* note 26, at 163-64.

41. But cf. BUREAU OF CONSUMER PROTECTION, FTC, *Standards and Certification* 275 (1983), stating that a standard-setting program "restrains trade by diverting business

provides a specific defense for many concerted efforts to influence public opinion and governmental action. Representations by competitor groups to licensing authorities should enjoy substantial protection against antitrust attack under this doctrine. The first amendment considerations underlying the *Noerr-Pennington* doctrine's narrow construction of the Sherman Act⁴³ should also inspire a favorable view of collective efforts by peer reviewers to inform consumers and their agents on subjects relevant to consumer welfare.⁴⁴

from one competitor to another." *Id.* Although this view is probably widely shared by the unsophisticated (the Bureau of Consumer Protection is not the FTC's antitrust enforcement arm), it is incorrect because, whatever influence a private body's standards may have, the competitive process remains unimpaired.

42. The *Noerr-Pennington* doctrine was developed in three Supreme Court cases. In *Eastern R.R. Presidents Conference v. Noerr Motor Freight, Inc.*, 365 U.S. 127 (1961), the Court held that the Sherman Act did not apply to the railroads' deceptive use of the media to procure legislation adverse to trucking interests. *See id.* at 138, 145. The Court cautioned that:

There may be situations in which a publicity campaign ostensibly directed toward influencing governmental action, is a mere sham to cover what is actually nothing more than an attempt to interfere directly with the business relationships of a competitor [in which case] the application of the Sherman Act would be justified.

Id. at 144. *See also* *United Mine Workers v. Pennington*, 381 U.S. 657, 670 (1965) ("[j]oint efforts to influence public officials [did] not violate the antitrust laws even though intended to eliminate competition"). In *California Motor Transp. Co. v. Trucking Unlimited*, 404 U.S. 508, 510-11 (1972), the Court extended the concepts established in *Noerr* and *Pennington* to shelter concerted activities aimed at influencing administrative agencies or courts to take actions harmful to competitors. In spite of the argument that the established truckers were merely petitioning their government, allegations of their concerted and excessive opposition to the grant of new operating authority were held to bring their actions within the *Noerr* decision's "sham" exception to the general principle that antitrust law should not frustrate the exercise of political rights. *See id.* at 515-16.

43. Some cases erroneously treat the *Noerr* doctrine as a constitutional check on the reach of the Sherman Act, implying that the Act reaches by its terms any action taken to procure a political or regulatory result that does not qualify as protected speech. *E.g.*, *Crown Central Petroleum Corp. v. Waldman*, 486 F. Supp. 759, 766 (M.D. Pa.), *rev'd on other grounds*, 634 F.2d 127 (3d Cir. 1980) (condemning a boycott for political purposes because it was "conduct beyond pure speech used to petition the government"). The better view is to treat the *Noerr* doctrine as simply a narrow construction of the Sherman Act. *See, e.g.*, *Missouri v. National Org. for Women*, 620 F.2d 1301 (8th Cir.), *cert. denied*, 449 U.S. 842 (1980) (construing the Sherman Act not to apply to boycott of convention facilities in Missouri aimed at getting state to ratify Equal Rights Amendment). *See generally* Raup, *Medicaid Boycotts by Health Care Providers: A Noerr-Pennington Defense*, 69 IOWA L. REV. 1393 (1984).

44. Rather than becoming entangled in first amendment issues (*see supra* note 43), courts should recognize that competitive markets, which the Sherman Act protects, require information and opinion to function smoothly. Thus, the first amendment and the Sherman Act, far from being in conflict, have similar objectives. Indeed, recent decisions declaring impediments to the flow of commercial information unconstitutional are expressly based on the value of such information to consumers, thus reflecting a policy concern identical to that underlying the antitrust laws. *See, e.g.*, *Bates v. States Bar of Arizona*, 433 U.S. 350, 364

A defense for peer-review programs that implicitly equates them with public regulatory agencies is misguided precisely because, instead of demanding that the plaintiff demonstrate that trade has been restrained, it concedes the false doctrine that an injury to a competitor is an injury to competition and is to be condemned unless it was inflicted for a worthy purpose. It thus invites close judicial scrutiny to determine the "reasonableness" of the peer reviewers' particular action, entailing a lengthy trial to elicit all the facts bearing on the merits of the action and the motives of the parties. Even if this defense succeeds, it may do so only after exhaustive and expensive litigation. By allowing a plaintiff-physician to equate his welfare with that of consumers, the usual defense of peer-review activity diverts attention from the procompetitive value of the overall effort and, by letting a jury guess at motives, increases the chance that liability will be found.⁴⁵

An irony here is that the willingness of the defense side in a peer-review case to concede the main premise of the plaintiff's complaint probably originates with the peer reviewers themselves. Professionals engaged in peer review tend to view their activities as being comparable to public regulation and not as merely an effort to generate information and advice useful to consumers.⁴⁶ The medical profession's long tradition of simultaneously denying the efficacy of market forces in health care and resisting government regulation has led professionals to assume that they are expected to regulate themselves. Under an antitrust regime, however, there is almost no room for competitor-sponsored private *regulation*, if that term is narrowly defined as actual control of market behavior by agreements to engage in or eschew particular conduct or to impose coer-

(1977) (commercial speech has indispensable role in resource allocation); *Virginia State Bd. of Pharmacy v. Virginia Citizens Consumer Council*, 425 U.S. 748, 763 (1976) (consumer interest in commercial information as keen as political interest). For a discussion of these policy issues in connection with the antitrust treatment of private accrediting, credentialing, and standard-setting programs, see Havighurst & King, *supra* note 26, at 194-97.

45. For comparable arguments aimed at reducing the antitrust risks of other professional bodies engaged in legitimate quality-assurance activities, see Havighurst & King, *supra* note 26, at 169-84, 189-201 (accrediting and credentialing programs), and Havighurst, *supra* note 15, at 1108-39 (medical staff and hospital decisions on admitting privileges).

46. If anything, increased competition in the health field puts the patient at greater risk and requires sophisticated and accurate regulatory efforts to protect both patients and payers, or rather, taxpayers. I am convinced that the PSROs remain the best, most accurate, and most sensitive regulatory mechanism available for the protection of those at risk.

PSRO Proposals: Hearings Before the Subcomm. on Health of the Comm. on Finance, 97th Cong., 2d Sess. 141-42 (1982) (presentation of Michael R. McGarvey, M.D., on behalf of the New York Statewide Professional Standards Review Council, Inc.) See also *infra* note 49.

cive sanctions on those who violate privately promulgated standards.⁴⁷ The illegality of such self-regulation lies, not in the collaborative setting of standards, but in the agreements by which they are enforced or otherwise implemented. Trade is not restrained by the nonregulatory acts of setting standards and publicizing the fact that some providers are not meeting them. Although physicians may need to modify their definition of professionalism somewhat to accommodate the requirements of competition, the medical profession should be free to organize in order to advise particular clients or the general public concerning the price, appropriateness, and quality of health services.

The distinction made here between harming competitors by collectively refusing to deal with them and harming them by collectively influencing others will strike many as hairsplitting. This reaction reflects the continued confusion between harm to a competitor and harm to competition. As long as the ultimate decisions—whether to comply with the standards oneself, to insist upon compliance by others with whom one deals, or to seek, believe, or act upon the peer reviewers' advice—continue to be made independently in the marketplace, the competitive process continues to operate. Indeed, giving independent decision makers information as to whether certain standards are being followed actually aids the competitive process; even if the standards are poorly chosen or improperly applied, the process itself is not impaired.

The forgoing conclusion, which is drawn by focusing on the integrity of the process itself and not on the outcome of the process in particular instances, is supported by analogy to the first amendment. The American free speech tradition presumes that the provision of more, even inconsistent, information and advice to consumers is desirable and that imposing high standards of truthfulness and objective accuracy unacceptably chills the production of information and opinion. The competitive marketplace is, in the American system, the best place to sort out truth from falsehood.⁴⁸

47. See *supra* note 36.

48. For a lengthy development of the thesis that the production of information and opinion regarding professional services should be neither closely regulated by courts nor monopolized by professional interests, see Havighurst & King, *supra* note 26. That Article draws at critical points on the first amendment tradition, noting that many of the issues are as much ideological as technical or scientific. See *id.* at 189-97; Havighurst & King, *Private Credentialing of Health Care Personnel: An Antitrust Perspective* (pt. 2), 9 AM. J. L. & MED. 263, 288-97. No positive value should be attached to the obtaining of a single, authoritative judgment on questions related to fees, utilization, or quality; see *infra* text accompanying notes 112-20.

IV. PEER REVIEW IN AN HISTORICAL AND POLICY CONTEXT

The foregoing legal defense of professional peer review rests upon a narrower conception of peer review than that which generally prevails in the medical community and in the health care industry as a whole. Both professional and lay observers assume that peer review is more than a source of useful, procompetitive information and opinion. Most believe that peer review is intended to provide definitive answers to the crucial questions lying at the heart of each medical care transaction: whether the service was appropriate, its quality acceptable, and its price fair.⁴⁹ Indeed, the original premise of professional peer review was that the medical profession was the sole legitimate authority on all such matters.⁵⁰ To the extent that final decisions on such crucial economic issues were thus placed in professional hands, the marketplace was unable to resolve trade-offs between quality and cost, to translate consumer preferences into provider performance, and to allocate society's scarce resources among alternative medical and nonmedical uses. Because the antitrust laws are offended by producers' impairments of the competitive process and infringements on consumer sovereignty, professional peer review must be examined in its actual historical context to determine whether the theoretical defense offered for it above may misapprehend reality.

The authority of professional norms and standards and of the professional bodies that enunciate and apply those norms and standards was long taken for granted in the health care field. Public and private health plans, by undertaking to cover all medically necessary care, implicitly accepted the practice standards that prevailed in the professional community as the appropriate measure of their responsibility to pay.⁵¹ It followed naturally from the premise implicit in these plans that profession-sponsored peer-review bodies should decide the liability of health insurers in close cases. The federal PSRO program, under which local professional bodies were ex-

49. The following statement is typical: "As a physician I have always been supportive of efforts which help to ensure that patients are assured a common standard of care regardless of the source of reimbursement." Hearing on PSRO Proposals, *supra* note 30, at 156 (statement of John Graham, President, Foundation for Health Care Evaluation, Minneapolis).

50. Senator Wallace Bennett viewed the Professional Standards Review Organization Act of 1970 as providing physicians with "an imaginative and exciting opportunity to assume basic responsibility for reviewing health care as a whole." 116 CONG. REC. 22,475 (1970).

51. See e.g., *Union Labor Life Ins., Co. v. Pireno*, 458 U.S. 119, 123 (1982) (chiropractor peer review committee offered advice as to medical necessity and reasonable prices); see also Havighurst, *Decentralizing Decision Making: Private Contract Versus Professional Norms*, in *MARKET REFORMS IN HEALTH CARE* 22, 24-28 (J. Meyer ed. 1983).

pressly allowed to define appropriate utilization and thus to decide the extent of the federal government's commitment to pay for professional services, was the most striking manifestation of deference to professional authority.⁵²

The UCR-fee approach to physician compensation, also widely employed in both public and private financing programs, was founded on the assumption that prices, too, are a matter appropriately left to expert professional judgment. In effect, payors went along with the medical profession's claim that the great majority of physicians, as ethical practitioners, would not, by demanding more than a reasonable fee, abuse the pricing discretion they enjoyed by virtue of third-party financing.⁵³ In addition, the profession was deemed the ultimate authority on quality issues. For instance, malpractice jurisprudence looks to customary practice for standards by which to judge liability issues.⁵⁴

Assertions of the authority of professional standards in the health care system took other forms as well. In addition to offering peer-review programs to resolve quality/cost trade-offs in light of professional norms, the organized profession presided over the creation and operation of a closely coordinated system of other standard-setting and certifying bodies. These entities prescribe such standards as the nature and content of medical education and post-graduate training, the qualifications of medical specialists, the training and credentialing requirements in the so-called "allied" health professions, and the internal organization and operation of hospi-

52. See generally Havighurst & Blumstein, *supra* note 23.

53. The UCR approach . . . is ultimately based on the assumption that physicians on the whole do not abuse their wide pricing discretion and, as ethical practitioners, charge no more than "reasonable" fees; the "peer-review" approach to limiting professional fees is based on the same unacceptable (in antitrust analysis) premise. If the private market, in which insurance covers the bulk of the outlays, is to yield competitive levels of professional fees, private third-party payers must be permitted and encouraged to take a more direct hand in negotiating fees with individual practitioners or in establishing fee schedules which individual physicians may or may not accept as adequate compensation for serving patients in the insured group.

Havighurst & Kissam, *supra* note 28, at 75-76.

54. For general discussions of the standard of care, indicating the strong de facto presumption in favor of those using mainstream methods, see J. KING, *THE LAW OF MEDICAL MALPRACTICE IN A NUTSHELL* 39-76 (2d ed. 1985); W. PROSSER & W. KEETON, *THE LAW OF TORTS* § 32, at 185-89 (5th ed. 1984); King, *In Search of a Standard of Care for the Medical Profession: The "Accepted Practice" Formula*, 28 VAND. L. REV. 1213, 1234-75 (1975); McCoid, *The Care Required of Medical Practitioners*, 12 VAND. L. REV. 549, 605-09 (1959). Cf. Havighurst, *Altering the Applicable Standard of Care*, 49 LAW & CONTEMP. PROBS., Spr. 1986, at 256, 266 nn.6-12 (arguing that the customary-practice standard is adopted for convenience, not because it is necessarily a good guide to appropriate practice); Havighurst, *supra* note 51, at 28-41.

tals. The profession also sought at one time to prescribe the nature of private health care financing programs by specifying the characteristics of plans with which physicians could ethically cooperate.⁵⁵

By these various measures, the medical profession succeeded in establishing both its claim that doctors know best and its paradigm of a unitary health care "system"⁵⁶ which produces a uniform, scientifically designed product and supplies its own internal mechanisms for standardizing output. Under this paradigm, consumers are not sovereign decision makers but passive beneficiaries entitled to whatever services the ostensibly benign system prescribes.

Because health care issues were defined as being purely scientific and ethical, cost was viewed as an improper consideration in determining the system's appropriate response to a particular medical problem. A fortiori, the system could not allow cost to affect a consumer's choice regarding medical treatment. Cost was therefore systematically excluded from the consumer's decision making by a variety of insurer practices, most of them dictated by law or professional fiat. As a result, the system was able to ignore the marginal trade-offs between medical care and other things that the consumer might value. Consumers and lay intermediaries, such as insurers and hospital boards, were deprived of the opportunity to exercise their own judgment on such matters, even with independent professional advice. With the medical profession making all the economically important choices,⁵⁷ health care claimed each year a disturbingly larger share of the gross national product.

55. See Havighurst, *Professional Restraints on Innovation in Health Care Financing*, 1978 DUKE L.J. 303, 306-19 (description of methods used by profession to suppress innovation); Goldberg & Greenberg, *The Effect of Physician-Controlled Health Insurance: United States v. Oregon State Med. Soc'y*, 2 J. HEALTH POL., POL'Y & L. 48 (1977); Comment, *The American Medical Association: Power, Purpose and Politics in Organized Medicine*, 63 YALE L.J. 937, 976-96 (1954) (AMA efforts to dictate terms of financial plans).

56. This term, implying central direction, was always employed instead of *industry*. For a fuller statement of the dominance of the old paradigm and its recent breakdown, see Havighurst, *Private Reform of Tort-law Dogma: Market Opportunities and Legal Obstacles*, 49 LAW & CONTEMP. PROBS., Spr. 1986, at 143, 145-56.

57. Sociologist Paul Starr has documented the medical profession's rise to a position of "cultural authority, economic power, and political influence." P. STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* 5 (1982). Charles Weller has shown how the profession acted as a guild, foisting its own version of free choice without price competition on a passive public. Weller, *"Free Choice" as a Restraint of Trade in American Health Care Delivery and Insurance*, 69 IOWA L. REV. 1351 (1984); Weller, *Antitrust and Health Care: Provider Controlled Health Plans and the Maricopa Decision*, 8 AM. J. L. & MED. 233 (1982) [hereinafter cited as Weller, *Antitrust and Health Care*]. For other surveys of the profession's domination of its economic environment, see Havighurst, *The Doctors' Trust: Self-Regulation and the Law*, 3 HEALTH AFF., Fall 1983, at 64; Havighurst, *supra* note 55.

Obviously, the model of a monolithic, self-regulating health care system could not be squared with the procompetitive policies of the antitrust laws. Consequently, when the health care industry began to come under antitrust scrutiny following the Supreme Court's 1975 decision in *Goldfarb v. Virginia State Bar*,⁵⁸ many of the foundations on which the medical profession's dominance was built began to crumble. The Federal Trade Commission (FTC) successfully attacked the ethical codes that limited the ways in which physicians could market their services.⁵⁹ Successful challenges were also mounted against professional boycotts of HMOs and of third-party payors that sought to make professionals compete on the basis of price.⁶⁰ Control by powerful professional organizations of prepayment plans was also questioned.⁶¹ These antitrust initiatives against professional restraints opened the door for substantial innovations in the delivery and financing of health care. Payors are today forcing physicians to engage in price competition.⁶²

Since the late 1970's, active antitrust enforcement and a congressional disinterest in strengthening public regulation have shifted power and the responsibility for the overall performance of the health care industry toward consumers and their agents and away from government and the industry's self-regulatory mechanisms. The resulting decentralization of decision making has given consumers a greater voice in the directions taken. These changes in the locus of decision making have gradually undermined the idea that there is a single correct way to treat each medical problem, discoverable only in the medical profession's accepted practice and collec-

58. 421 U.S. 773, 786, 791-92 (1975) (no implied exemption for learned professions; state bar's minimum fee schedule violates antitrust laws).

59. *AMA v. FTC*, 638 F.2d 443 (2d Cir. 1980), *aff'd by an equally divided Court*, 455 U.S. 676 (1982).

60. *See, e.g., In re Michigan State Med. Soc'y*, 101 F.T.C. 191, 254 (1983) (society's refusal to deal with certain medical insurers held to be restraint of trade); *United States v. Halifax Hosp. Med. Center*, 1981-1 Trade Cas. (CCH) ¶ 64,151 (1981) (consent decree).

61. *See* FTC, Statement of Enforcement Policy, 46 Fed. Reg. 48,982, 48,984 (1981); BUREAU OF COMPETITION, FTC, STAFF REPORT ON MEDICAL PARTICIPATION IN CONTROL OF BLUE SHIELD AND OTHER OPEN-PANEL MEDICAL PREPAYMENT PLANS (Apr. 1979).

62. *Cf. Ball Memorial Hosp. v. Mutual Hosp. Ins., Inc.*, 784 F.2d 1325 (7th Cir. 1986); *Brillhart v. Mutual Med. Ins., Inc.*, 768 F.2d 196 (7th Cir. 1985) (rejecting challenge to insurer/physician fee agreements); *Kartell v. Blue Shield*, 749 F.2d 922 (1st Cir. 1984) (rejecting physician complaints about hard bargaining by alleged monopolist); Rice, de Lissoy, Gabel & Ermann, *The State of PPOs: A National Survey*, 4 HEALTH AFF., Winter 1985, at 25 (documenting the growth of plans facilitating physician price competition).

tive wisdom.⁶³

As consumers and their allies have placed cost considerations alongside quality-of-care concerns, traditional methods of treating medical problems have been increasingly called into question. As a result, hospital stays are shorter, occupancy rates are down, and professional styles of practice are changing.⁶⁴ In general, consumer choice is proving to be a useful corrective measure for physicians' myopic tendency to focus on the presumed benefits of their services while ignoring the cost and side effects of their ministrations. Increased consumer awareness has also provided new emphasis on such alternatives as prevention, outpatient services, and nonphysician personnel.⁶⁵ Although consumers still value the opinions of the medical profession, consumer choice is beginning to undermine the tyranny of professional standards. Professional peer review is no longer the powerful homogenizing force that it once was.

Although antitrust law has facilitated this revolution⁶⁶ in the ways in which professional services are marketed, it has not yet challenged all the mechanisms by which the medical profession ef-

63. For fuller exposition of this breakdown, see Havighurst, *supra* note 56, at 145-56. See also Havighurst, *supra* note 51, at 28-35. Consumers and others are discovering that medicine is a far less perfect science than has commonly been recognized and that there are many open questions of efficacy, safety, and cost effectiveness that make diversity and decentralized decision making appropriate. See *infra* note 65.

64. See, e.g., Davis, Anderson, Renn, Rowland, Schramm & Steinberg, *Is Cost Containment Working?*, 4 HEALTH AFF., Fall 1985, at 81.

65. Questions about the consistency and reliability—and indeed about the scientific basis—of professional norms and standards are being increasingly raised, with the result that medicine is being demystified. See, e.g., *Variations in Medical Practice*, 3 HEALTH AFF., Summer 1984 (focusing on the work of John Wennberg, M.D., showing wide inconsistencies in medical practices from area to area); Eddy, *Clinical Policies and the Quality of Clinical Practice*, 307 NEW ENG. J. MED. 343 (1982) (documenting the view that "there is reason to believe that there are flaws in the process by which the profession generates clinical policies").

66. See, e.g., Havighurst, *The Contributions of Antitrust Law to a Procompetitive Health Policy*, in MARKET REFORMS IN HEALTH CARE 295-96 (J. Meyer ed. 1983). The "revolution" is far from complete, but its progress is suggested by the following thoughts of an opinion pollster:

Historians looking back on the 1980s will report that the nation's health care system was profoundly changed during this decade. They will note . . . increasing competition among health care providers; fundamental changes in delivery of health care services and in the institutions that deliver them; and a revolution in the way that health care services are sold and paid for. They may also be able to note that—after years of escalating health care costs—private sector costs were brought under control. And, if they are perceptive, they will report that the public's behavior, attitudes, and expectations about health care providers also shifted dramatically.

Some things have not changed, including our priorities. Americans want a health care system that provides first-rate care with a human face, that is accessible to everyone, including the old and the poor, and that is affordable.

Taylor, *Healing the Health Care System*, PUB. OPINION, Aug.-Sept. 1985, at 16.

fectively standardizes health care institutions, personnel, and services. Accrediting and credentialing programs are now forced to account for the reasonableness of their standards and for the way in which they are applied in particular cases.⁶⁷ The legitimacy of these programs is generally accepted, however, and in the final analysis their actions enjoy substantial deference. One reason for the acceptance of these programs is that standardization is not undesirable *per se* and indeed can enhance efficiency in a market characterized by consumer ignorance and insurance-induced distortions in behavior. On the other hand, enforcement agencies and private plaintiffs have not raised any concern about the profession's near-monopoly of standard setting, accrediting, and certification. If the desirability of competition in the production of such information and opinion were recognized, many professional activities aimed at giving the public only a single, professionally validated opinion on a particular issue might be open to a new kind of antitrust challenge.⁶⁸

Because profession-dominated peer review was historically an important element in the infrastructure of controls by which the medical profession retained vital decisions in its own hands, it must be reexamined in light of the specific concern that excessive standardization may deprive consumers of options that they should be allowed to exercise in a free, competitive market. If professional peer review still serves to disenfranchise consumers and to remove important issues of price and value from the competitive arena, it may yet violate the Sherman Act. The ultimate issue, however, is whether such professional activities are consistent with the decentralization of decision making that is the essential element of a competitive market and, therefore, the essential concern of antitrust law. The next three sections of this Article consider distinct anticompetitive effects and suggest legal rules that can preserve the benefits of peer review while protecting against the hazards observed.

V. EFFECTS OF PEER REVIEW ON COMPETITION AMONG ITS PROFESSIONAL SPONSORS

Antitrust law's first concern with respect to competitor collabo-

67. See, e.g., *Kreuzer v. American Academy of Periodontology*, 735 F.2d 1479, 1489 (D.C. Cir. 1984). See generally *Havighurst & King*, *supra* note 26, at 169-84 (arguing for judicial restraint).

68. See *Havighurst & King*, *supra* note 48, at 295-325 (applying antitrust principles to restraints on the production of data and opinion informing purchases in health care); see also *infra* text accompanying notes 112-20.

ration is its effect on competition among the collaborators themselves. Profession-sponsored peer review might perhaps be challenged for its adverse effects on such competition on the basis of the Supreme Court's holding in *Arizona v. Maricopa County Medical Society*.⁶⁹ In that case, the Court found that two broadly based foundations for medical care committed per se violations of the Sherman Act when they bound their members to charge no more than agreed-upon prices to patients insured by foundation-approved health insurance plans. Although these voluntary fee limits can be viewed as cost-containment measures responsive to public concern about the excessive charges of some physicians, the Court condemned them as simple price fixing.⁷⁰ A profession-sponsored peer-review body enunciating standards for judging the pricing or provision of medical care might be viewed in comparable fashion. Competitors promulgating such standards, the argument could go, stand on the same footing as the defendants in the *Maricopa* case because they are tampering with physicians' pricing or output decisions.⁷¹

69. 457 U.S. 332 (1982). Because it was decided by a bare four to three majority (Justices Blackmun and O'Connor not participating), this case may be weak authority for applying strict antitrust rules to concerted activity of professionals.

70. The dissenting opinion in *Maricopa* characterized the challenged medical care plan as "a comparatively new method of providing insured medical services at predetermined maximum costs" and observed that "the plan seems to be in the public interest." *Id.* at 357. The majority accepted as true the defendants' claim that the maximum fee schedule "serve[d] as an effective cost containment mechanism that ha[d] saved patients and insurers millions of dollars." *Id.* at 342. It concluded, however, that the Sherman Act was "'grounded on faith in price competition as a market force [and not] on a policy of low selling prices at the price of eliminating competition.'" *Id.* at 348 (quoting Rahl, *Price Competition and the Price Fixing Rule—Preface and Perspective*, 57 NW. U.L. REV. 137, 142 (1962)).

It would seem fortunate that the majority carried the day and refuted the once-prevalent idea that the organized medical profession is collectively responsible for solving the problem of health care costs. For advocacy of this result and a demonstration that professional efforts are unlikely to save consumers money in fact, see Havighurst & Hackbarth, *supra* note 15.

The dissenting justices in *Maricopa* also criticized the majority's application of the per se rule to the medical plans. See 457 U.S. at 357, 361-65. This criticism was also voiced by many commentators. See e.g., Gerhart, *The Supreme Court and Antitrust Analysis: The (Near) Triumph of the Chicago School*, 1982 SUP. CT. REV. 319, 344-48 (wooden application of per se rule seen as retrogressive); Easterbrook, *Maximum Price Fixing*, 48 U. CHI. L. REV. 886, 900-08 (1981) (application of per se rule is inappropriate absent examination of benefits of maximum price fixing). Although criticism of Justice Stevens' statement of principles is justified, the result he reached and the analytical method actually employed—examining the claim of procompetitiveness after seeming to say that the Court lacked power to do so (457 U.S. at 351-54)—are both defensible. See, e.g., Weller, *Antitrust and Health Care*, *supra* note 57, at 233-42; Leffler, *Arizona v. Maricopa County Medical Society: Maximum-Price Agreements in Markets with Insured Buyers*, 2 SUP. CT. ECON. REV. 187, 189 (1983) (correct result but automatic application of per se rule inappropriate).

71. Because price and output are related, so that agreements increasing one reduce the other and vice versa, both should be of equal antitrust concern. "Restrictions on price and

The *Maricopa* case does not, however, resolve the legal status of professional peer review. The specific vice that led to condemnation of the maximum fee schedules in that case was the explicit agreement of the foundation members to adhere to the prescribed maximums. Peer-review bodies do not, as a general rule, bind their members (or anyone else) to adhere to the standards they set. Instead, standards are ostensibly established only for the purpose of reviewing particular bills or services or a particular physician's performance. If the findings of these reviews are given effect only through the actions of independent decision makers, there is no basis, as there was in *Maricopa*, for finding a naked agreement of competitors to surrender their competitive freedom. Instead, physicians retain their freedom to charge fees that the peer reviewers may not approve, to prescribe services that the peer reviewers may find unnecessary, and to provide a quality of service that the peer reviewers would declare substandard. If a true horizontal restraint is to be discovered, one must either look more deeply or look elsewhere.

A deeper look at profession-sponsored peer review does reveal a problem when the reviewers go beyond evaluating care on an ad hoc, retrospective basis and promulgate advisory fee schedules or ethical practice standards to guide future professional conduct. The most troublesome possibility is that such standards reflect or invite actual or tacit agreement by the sponsoring professionals to abide by them or to boycott those who do not abide. Even if no such agreement to follow or to enforce the standards is discoverable, a peer-review program still embodies concerted action subject to anti-trust scrutiny. Where the members of a useful joint venture collectively possess market power, courts can require that they carry out their beneficial activities in ways that pose no undue hazard to competition.⁷² Some implications of this rule will be noted below.

output are the paradigmatic examples of restraints of trade that the Sherman Act was intended to prohibit." *National Collegiate Athletic Ass'n v. Board of Regents*, 104 S. Ct. 2948, 2964 (1984). See also *United States v. Socony-Vacuum Oil Co.*, 310 U.S. 150, 223 (1940) ("Under the Sherman Act a combination formed for the purpose and with the effect of raising, depressing, fixing, pegging, or stabilizing . . . price . . . is illegal *per se*."). For these reasons, output-limiting utilization standards, even for cost-containment purposes, might be even more troublesome to an antitrust court than maximum fee control. It is notable, however, that the foundations' utilization-review activities were not challenged and seemed unimpeachable to the court of appeals. *Arizona v. Maricopa County Med. Soc'y*, 643 F.2d 553, 557 (9th Cir. 1980) ("No one suggests that peer [utilization] review is suspect . . .").

72. E.g., *Silver v. New York Stock Exchange*, 373 U.S. 341 (1963) (discussed *infra* notes 100-03 and accompanying text); *United States v. Realty Multi-List, Inc.*, 629 F.2d 1351 (5th Cir. 1980). The less-restrictive-alternative requirement is a sound one but should be viewed as a test for an arrangement's basic reasonableness, not as an invitation to courts to regulate

A. *Do Collective Standards Imply a Horizontal Agreement to Abide by Them?*

Although collective standard setting does not inevitably involve an agreement by the sponsors to compete only in ways that meet professional approval, it may easily involve such an agreement in fact. It is extremely difficult for the parties to a collective standard-setting effort to maintain in practice the distinction between lawfully agreeing to promulgate standards and unlawfully agreeing not to deviate from them.⁷³ Courts would be hard pressed to detect whether the distinction had been observed in a particular case. Because authoritative standards invite professionals mutually to refrain from unapproved competitive methods and because courts could never be certain whether uniform compliance reflected unilateral choice or collective action,⁷⁴ it may be too simplistic to presume that professionally promulgated standards are merely advisory and affect professional conduct only through the independent actions of those who unilaterally decide to respect them.

Because, at some point, the effort to distinguish between an agreement to set standards and an agreement to adhere to them becomes strained, it may be more honest to consider the possibility that some intraprofessional agreements to establish *and* abide by minimum standards of performance should be tolerated by antitrust law. Such an exception to the statute's flat prohibition of "[e]very . . . restraint of trade" has frequently been suggested as a way of recognizing the special character of professional services.⁷⁵ Con-

all collective action. See P. AREEDA, *supra* note 11, at 9; Havighurst & King, *supra* note 26, at 178-84.

73. For a discussion of this distinction in another context (educational accrediting), see Havighurst & King, *supra* note 48, at 308-11. See also *In re National Macaroni Mfr. Ass'n.*, 65 FTC 583 (1964), *aff'd*, 345 F.2d 421, 426 (7th Cir. 1965) (prohibiting standard setting that amounts to an agreement among association members to reduce the proportion of durum wheat in macaroni in an effort to depress the price of that component).

74. Proving the requisite collusion requires more than a showing of "conscious parallelism." See *Theatre Enter., Inc. v. Paramount Film Distrib. Corp.*, 346 U.S. 537, 541 (1954). Parallel conduct attributable to oligopolistic interdependence may be unlawful even if an actual agreement to refrain from competitive behavior cannot be inferred. See *Interstate Circuit, Inc. v. United States*, 306 U.S. 208, 222, 223 (1939). An inference of actual or tacit collusion is generally recognized as permissible where the parallel conduct would be contrary to the self-interest of each individual competitor unless all competitors acted in the same manner. See *Ambook Enter. v. Time, Inc.*, 612 F.2d 604, 614 (2d Cir. 1979), *cert. dismissed*, 448 U.S. 914 (1980). In the professional setting, where individual professionals might act against economic self-interest for personal or ethical reasons, these usual tests for establishing conspiracies are particularly difficult to apply. See *infra* note 83.

75. Courts have occasionally indicated a willingness to extend special treatment to professionals under the antitrust laws by excusing restraints imposed for ethical or public-service

ceivably a worthy purpose might be allowed to justify some restraints without throwing open the door entirely to unguided policy judgments about whether competition is desirable in every case.⁷⁶ Indeed, it can be argued that if the law does no more than make allowance for the reality that markets are imperfect, it leaves the underlying paradigm of competition unchallenged.⁷⁷ Unlike the public-safety claims offered in support of an ethical canon against competitive bidding for professional engineering services in the leading case rejecting worthy-purpose defenses, a narrow market-failure defense for an agreement to adhere to a profession's official practice standards might escape being characterized as "a frontal assault on the basic policy of the Sherman Act."⁷⁸

Its sweeping language notwithstanding, the Sherman Act has never been construed to condemn all naked, nonancillary restraints.⁷⁹ One reason for not automatically condemning all agreements under which competitors nakedly limit the methods by which they compete might be simply that antitrust law, if it is to retain credibility as national policy, ought not to appear mindless in its attachment to competition. Partly for this reason, the antitrust enforcement agencies have always been willing to listen to claims that small infringements on competition serve consumer interests. In addition to protecting the enforcers against the charge that they are wedded to competition as an end in itself and not as an instrument

reasons. *See, e.g.,* National Soc'y of Professional Engineers v. United States, 435 U.S. 679, 696 (1978) (dictum); Goldfarb v. Virginia State Bar, 421 U.S. 773, 788-89 n.17 (1975) (dictum); Wilk v. AMA, 719 F.2d 207, 221-22 (7th Cir. 1983), *cert. denied*, 104 S. Ct. 2398 (1984); Indiana Fed'n of Dentists v. FTC, 745 F.2d 1124, 1139 (7th Cir. 1984), *rev'd*, 106 S. Ct. 2009 (1986). No court has yet articulated a doctrinally sound way to make such exceptions, however. The ensuing text suggests a possibility but concludes that an exception is not needed and that clear thinking about whether competition is actually being harmed will serve the same purpose better and create less uncertainty.

76. *See supra* note 15 for the arguments against a worthy-purpose defense.

77. The suggestion is that a limited and principled exception to the rule requiring unrestricted rivalry might be made in cases where the theory underlying the policy of promoting competition is invalidated by the presence of a demonstrable market failure and where the restraint in question could reasonably be expected to make actual market outcomes resemble more closely the outcomes in an efficient market. *See* P. AREEDA, *supra* note 11, at 5-8. It is possible that the need for such an exception is more theoretical than real, however, and that real-world competitors could seldom be trusted to make the imperfect market serve consumer interests better. *See infra* note 82. Although Areeda offers a hypothetical case that seems to warrant an exception (*see id.* at 7-8, 11), he has found no comparable example of a proconsumer naked trade restraint in actuality.

78. National Soc'y of Professional Engineers v. United States, 435 U.S. 679, 695 (1978). The Court in this case implied that, if the restraint had aimed at protecting only unsophisticated purchasers of complex services, it might have been viewed differently. *See id.* at 692.

79. *See* P. AREEDA, *supra* note 11, at 5-8.

for advancing consumer welfare, such openness gives the impression of flexibility in the law and thus weakens arguments for creating unwise statutory exemptions. Moreover, horizontal agreements to observe minimum standards often appear to reduce the need for government regulation or to compensate for inadequate regulation (by state licensing boards, for example) and thus to be desirable from a policy standpoint. Finally, the standards adopted often approximate the standards that the law itself imposes,⁸⁰ and it is hard to see any reason why antitrust law should object to competitor agreements to obey the law and monitor each other's compliance.⁸¹

Despite the foregoing arguments, it does not seem necessary or appropriate, at least in this instance,⁸² to tolerate explicit intraprofessional agreements to abide by ethical or practice standards.

80. See, e.g., *In re AMA*, 94 F.T.C. 980 (1979), *modified and enforced sub nom. AMA v. FTC*, 638 F.2d 443 (2d Cir. 1980), *aff'd mem. by an equally divided Court*, 455 U.S. 676 (1982). Even though it found the AMA and local societies guilty of Sherman Act violations in restricting professional advertising, the Commission's final order nevertheless left the societies an opportunity to prohibit "representations . . . that [it] reasonably believes would be false or deceptive within the meaning of Section 5 of the [FTC] Act." 638 F.2d at 452. Possible problems surrounding this order are discussed *infra* note 82.

81. In *Fashion Originators' Guild of Am., Inc. v. FTC*, 312 U.S. 457 (1941), an association of women's apparel distributors, designers, and manufacturers sought to prevent the unauthorized copying of fashion designs, which the Court assumed would be tortious conduct under state law. See *id.* at 468. Nevertheless, the Court, in declaring the Guild's conduct unlawful as a group boycott, characterized the Guild as "an extra-governmental agency, which prescribes rules for the regulation and restraint of interstate commerce." *Id.* at 465. The assumption of power to enforce "the law" creates dangers of selective enforcement and self-interested misinterpretation. See *infra* note 82.

82. Even if room exists in antitrust theory for offering narrow market-failure defenses for minor anticompetitive agreements (see *supra* note 77), such agreements by powerful professional groups should seldom be upheld. Analysis of them under the Rule of Reason should usually lead to the conclusion that the risks to consumers stemming from the professionals' inevitable conflict-of-interests outweigh the likelihood that their restraints will achieve true efficiency—that is, outcomes similar to those that would be yielded if the market functioned smoothly.

The FTC's order allowing the AMA to police false and deceptive advertising (see *supra* note 80) illustrates this risk. One could argue that such policing is procompetitive in that it rectifies a demonstrable market failure. However, the Commission's own demonstration of the medical profession's past hostility to competitive advertising demonstrates the unlikelihood that the profession would in fact use self-regulation to increase consumer confidence in professional advertising, thereby increasing such advertising's effectiveness as a competitive tool available to professionals. Furthermore, although it may appear that the FTC's order grants only narrow authority to enforce the FTC Act, the actual power granted may be quite broad because of the difficulty in detecting enforcement abuses and because of the "breathing space" necessarily afforded legitimate self-regulators by the courts. See *Silver v. New York Stock Exchange*, 373 U.S. 341, 360 (1962). Note also that the final order approved by the court of appeals permits the AMA to prohibit whatever it "reasonably believes" would be deceptive. 638 F.2d at 452. Because of the potential for abuse, even the power to agree not to compete by advertising deceptively may be too great to tolerate.

The procompetitive benefits of professional peer review may be obtained under a stricter rule that prohibits agreements to abide by standards but is not too quick to infer the existence of such agreements from circumstantial evidence, such as "conscious parallelism."⁸³ Although many voluntary standards are beneficial enough to competition to warrant overlooking any implicit agreement by their sponsors to refrain from unapproved conduct, it would be unsound doctrine and policy to go further and tolerate explicit intraprofessional agreements on the forms that competition may take. Such a concession to professional authority would perpetuate the belief that professional groups, rather than consumer choice, should finally dictate industry performance.

Under the foregoing formulation of the legal test, ethical and practice standards could be adopted by influential professional bodies without being viewed as the product of the sponsors' agreement to compete only in approved ways. Peer reviewers would have to present their standards, however, as being only advisory and not as professionally revealed truth. Although there are good reasons to disregard the irreducible element of agreement implicit in the promulgation of such standards, the law should insist that the standard setters preserve appearances of nonagreement as far as it is possible to do so. Thus, under the requirement that powerful competitor organizations must pursue their legitimate purposes by less restrictive or less dangerous means reasonably available to them, the peer reviewers should be barred from holding out their standards and enforcement actions as anything more than recommendations for the use of appropriate decisionmakers. When uniformity results, it should then be at least plausible to argue that it resulted only from supply and demand factors, not from explicit agreements to forgo certain behavior.

B. *The Form of Collective Standards*

Under the rule that competitors' collective actions for procompetitive purposes should be tailored to endanger competition as little as reasonably possible, peer reviewers' standards must be written and published in ways that are unlikely to dampen the vigor of com-

83. For a case in which the FTC seemed to jump too quickly to the conclusion that a conspiracy existed, see *In re Community Blood Bank of the Kansas City Area, Inc.*, 70 F.T.C. 728, 938-42 (1966), *rev'd on other grounds*, 405 F.2d 1011 (8th Cir. 1969). Dissenting Commissioner Elman, while correctly criticizing the majority's inference of a conspiracy from respondent professionals' behavior, was himself too willing to forgive a professional boycott to suppress commercial blood banks. See *id.* at 951-58; see *supra* note 74.

petition among sponsors of the program. For example, fee review, though useful to consumers and insurers as a grievance mechanism, would pose substantial dangers to competition if it employed an announced fee schedule or fee-setting formula that practitioners could easily use to set noncompetitive prices.⁸⁴ Fortunately, the danger that fee review will trigger pricing uniformity can easily be minimized by reviewing fees only on an ad hoc, retrospective basis and by eschewing publication of fee schedules or formulas.

The antitrust authorities appear to accept retrospective fee review that constitutes advice only to payors, not providers.⁸⁵ Thus, the FTC and the Justice Department have issued advisory opinions approving profession-sponsored, fee-review programs that (1) refrain from publishing their standards as a possible invitation to providers to increase their below-ceiling prices and (2) do nothing to force patients and insurers to employ the peer reviewers to the exclusion of other cost-containment methods.⁸⁶ Peer reviewers

84. See *supra* note 28.

85. *Bartholomew v. Virginia Chiropractors Ass'n*, 612 F.2d 812, 817-18 (4th Cir. 1979), *cert. denied*, 446 U.S. 938 (1980) (allowing professional association to advise insurers on whether fees meet UCR criteria); *Mize v. State Farm Mutual Automobile Ins. Co.*, 1984-1 Trade Cas. (CCH) ¶ 65,780 (N.D. Ga. Dec. 19, 1983) (chiropractic peer review committee's review of fees not a conspiracy to fix prices where merely advisory to an insurer). See also *infra* note 86. Other suggestive authorities include *Goldfarb v. Virginia State Bar*, 421 U.S. 773, 781 (1975) ("purely advisory fee schedule . . . a different question"); *AMA v. FTC*, 638 F.2d 443, 453 (2d Cir. 1980) (modifying FTC order so as not "to impinge upon valid activity such as professional peer review of the fee practices of physicians"), *aff'd mem. by an equally divided Court*, 455 U.S. 676 (1982); *United States v. American Soc'y of Anesthesiologists, Inc.*, 473 F. Supp. 147, 156 (S.D.N.Y. 1979) (accepting Society's relative value formula for pricing services because it was advisory only, despite evidence it had been used for local price fixing).

Although the latter decision seems wrong in its evaluation of benefits and harms and its refusal to apply a per se rule following a "quick look," there is ample support for the principle that advisory peer review should not be unlawful if properly structured and confined to serving that purpose. Commentators supporting this general conclusion include Borsody & Tiano, *supra* note 25, at 523-31; Note, *supra* note 25, at 57-67.

86. See, e.g., *Iowa Dental Ass'n*, 99 F.T.C. 648, 649-50 (1982) (advisory opinion); Letter from Donald I. Baker, Assistant Attorney General, U.S. Department of Justice to J. Brian Niederhauser, International Chiropractor Ass'n, Mar. 1977 (business review letter) (copy on file with author); Letter from M. Elizabeth Gee, Assistant Director, Bureau of Competition, FTC, to William T. McGuire, Passaic County Med. Soc'y, Jan. 3, 1986 (expressing the FTC staff's doubts concerning a fee-review program mandatory for and binding on society members) (copy on file with author); Letter from Arthur N. Lerner, Assistant Director, Bureau of Competition, FTC, to American Podiatry Ass'n, Aug. 19, 1983 (approving fee-review program) (copy on file with author); *United States v. Illinois Podiatry Soc'y*, 1977-2 Trade Cas. (CCH) ¶ 61,767 (N.D. Ill. 1977) (consent decree barring relative value guides but permitting advisory peer review). For provisions in FTC orders leaving room for peer review of fees, see *In re American Med. Ass'n*, 99 F.T.C. 440, 441 (Final Order, § II, May 19, 1982); *Michigan State Med. Soc'y*, 101 F.T.C. 191, 314 (Final Order, § III, Feb. 17, 1982). These orders and several other recent FTC actions have indicated a willingness (partly in recognition of first

should have no difficulty in abiding by these rules in policing excessive professional fees. In the present climate of the health care industry, insurers are less likely than in earlier days to rely exclusively upon profession-sponsored fee review. Payors are increasingly negotiating fees with physicians directly in advance, using the preferred-provider designation to steer patients away from high-priced practitioners.⁸⁷

Utilization review would likewise present a possible antitrust problem if it entailed the publication of profession-approved practice standards that invited practitioners to tailor their practice styles according to collective preferences rather than individual judgment. Nevertheless, it is hard to see any great threat to competition if the standards are only advisory.⁸⁸ The danger of inducing uniform provider behavior would seem substantially less than in the case of fee recommendations. In addition, the possible harm to consumers from receiving costly added services of small marginal utility is not as offensive to antitrust policy as the risk of noncompetitive prices.

Even if a particular insurer were to adopt a profession-sponsored peer-review body as the final arbiter, and its standards as the final measure, of its payment responsibilities, there would be no antitrust violation. The insurer's decision, if freely made, could be presumed to reflect the insurer's choice of a competitive strategy, subject ultimately to the verdict of the marketplace. This decision is reversible if the insurer or its customers should lose confidence in

amendment rights) to permit professional organizations to engage in discussions of fee-related issues with third-party payors. *E.g., id.* (§§ III-B and III-C); California Med. Ass'n, 3 Trade Reg. Rep. (CCH) ¶ 22, 243 (Apr. 24, 1985) (modification of consent decree); American Soc'y of Internal Med., 3 Trade Reg. Rep. (CCH) ¶ 22, 242 (Apr. 19, 1985) (similar); American Acad. of Orthopaedic Surgeons, 3 Trade Reg. Rep. — 22, 240 (Apr. 4, 1985) (similar); American College of Obstetricians & Gynecologists, 104 F.T.C. 524 (1984) (similar); Hawaii v. Hawaii Soc'y of Anesthesiologists, 1981-2 Trade Cas. — 64, 164 (Hawaii Cir. Ct. 1981) (consent decree under state antitrust law permitting society to advocate payment systems to third party payors).

87. The difficult cases will be those in which fee controls that are arguably ancillary to the operation of a procompetitive joint venture are questioned because of the joint venture's size and potential for impairing competition in the market as a whole. The Supreme Court, in *Maricopa*, made clear that integrated plans will not be exposed to per se treatment. See 457 U.S. at 355-57. The developing law on so-called "preferred provider" organizations and similar arrangements has explored this and related issues. *E.g.,* Ball Memorial Hosp. v. Mutual Hosp. Ins., Inc., 784 F.2d 1325 (7th Cir. 1986); Brillhart v. Mutual Med. Ins., Inc., 768 F.2d 196 (7th Cir. 1985); Health Care Management Assocs., 101 F.T.C. 1014 (1983) (advisory opinion); Remarks of J. Paul McGrath, Assistant Attorney General, U.S. Department of Justice, before the 33rd Annual ABA Antitrust Spring Meeting (Mar. 22, 1985).

88. See Rhode Island Professional Standards Review Org., 101 F.T.C. 1010 (1983) (FTC advisory opinion approving PSRO's private utilization program, which was advisory only and could, in the FTC's view, "promote competition").

the peer reviewers. As long as competing health plans are free to define the limits of their coverage by other means, consumers would not be deprived of the benefits of competition among the sponsors of the peer-review effort.

VI. EFFECTS OF PEER REVIEW ON THE COMPETITIVE FREEDOM AND OPPORTUNITIES OF THIRD PARTIES

In view of the role of peer review in operating the old medical monopoly, antitrust analysis should not stop with the discovery that profession-sponsored peer review is a procompetitive source of information and advice that does not impair horizontal competition among its professional sponsors. Peer reviewers may so dominate the provision of information and advice that competitors outside the sponsoring group or other participants in the market, including those standing in a vertical relationship to the sponsors, have no real alternative to accepting their prescriptions. Consumers may therefore be denied options that they might deem desirable. If a joint venture enjoys such pervasive influence,⁸⁹ its activities must be further scrutinized to ensure that the collaborators' purpose is indeed procompetitive and that their actions are taken in ways that minimize any danger to competition. Even if these tests are passed, the ability of the collaborators to preempt independent decision making by others could still be deemed sufficient to render the net effect of the peer-review program anticompetitive.

In the following discussions, profession-sponsored peer review for cost-containment purposes is treated separately from quality-oriented peer review because the potential harms to competition in the two cases take somewhat different forms.

A. *Peer Review for Cost Containment: Fee and Utilization Review*

Historically, there was a substantial danger that private health insurers would unanimously embrace the medical profession's pre-

89. See *supra* text accompanying notes 7-10 for the significance of market power in § 1 analysis. For present purposes, a distinction may be drawn between the market in which a peer-review body's sponsoring physicians compete and the market in which the peer-review body itself "competes." Power in the market for physician services may be created by the joint venture in question, but this is not the market power of concern in the remainder of this analysis. Instead, the joint venture should be scrutinized to determine whether it possesses power over the production of a specific type of information and opinion, the misuse of which could indirectly harm consumers. See generally *infra* text accompanying notes 112-20; Havighurst & King, *supra* note 48, at 299-300.

ferred methods of fee and utilization review, eschewing alternative methods of controlling their costs and in effect letting the profession dictate overall spending. Although this danger has diminished as competition has intensified, such unanimity could still appear in a given local market, warranting an antitrust investigation. If profession-sponsored peer review is instrumental in curbing insurers' competitive independence and thus protecting physicians from competitive pressures, antitrust law might be invoked to rectify the situation.

It appears that insurer competition in the containment of medical care costs is most likely to be suppressed by means other than mere profession sponsorship of fee or utilization review. Thus, insurers may have been overtly coerced to do business only in physician-approved ways.⁹⁰ The coercive measures should then be challenged directly, and the peer-review program should be disbanded or reconstituted only upon a showing that it was an instrumental part of a larger conspiracy. If coercion by providers is absent, the insurers' uniform acceptance of provider standards and decision making should be scrutinized to determine whether such "conscious parallelism" in forgoing efficacious competitive strategies was the product of unlawful insurer collusion, actual or tacit.⁹¹ Evidence that the peer reviewers organized or actively facilitated such collusion could make them guilty of antitrust violations as well.

In the past, noncompetitive conditions persisted at the interface between physicians and private third-party payors without much detectable coercion or collusion. Instead, the prevailing peace and harmony appeared to reflect a largely tacit but highly stable accommodation between a profession wishing to avoid price competition and an industry wishing to preserve its traditional insurance practices and to avoid competing in cost containment.⁹² This informal alliance to suppress competitive impulses on both sides of the market⁹³ has dissolved in many markets today as a result of pressures from cost-conscious employers, the new competitiveness of physi-

90. See *infra* text accompanying notes 115-18.

91. On proving conspiracy by circumstantial evidence, see *supra* note 74. For a review of the state of competition in markets for health insurance, see Havighurst, *Explaining the Questionable Cost-Containment Record of Commercial Health Insurers*, in *THE POLITICAL ECONOMY OF HEALTH CARE* (H.E. Frech ed.) (in press).

92. See *id.*

93. *Maricopa* provides an illustration. The foundation's maximum fee schedules bound physicians only when dealing with patients of *approved* insurers, which meant that insurers had to satisfy the doctors or face higher costs. See 457 U.S. at 353-54. Although the dissent-

cians, and antitrust inhibitions on the profession's own cost-control efforts, which have forced payors to assume unwanted cost-containment responsibilities themselves.⁹⁴ Nevertheless, there may still be markets in which competitive forces remain dormant and in which profession-sponsored fee and utilization review serve as the only detectable linchpin in the noncompetitive framework. In such a case, collective peer review could be condemned by a Rule of Reason finding that, in the particular circumstances, the harms to competition outweigh peer review's benefits.

Without near-universal adherence to the peer-reviewers' cost-containment program, profession-sponsored fee or utilization review easily meets the simple specifications laid down earlier and should be seen as fundamentally procompetitive and lawful.

B. *Peer Review for Quality Assurance*

Peer review may frequently limit the freedom of action of individual physicians who compete with the peer reviewers and their professional sponsors. Such effects are especially likely in the case of profession-sponsored quality assurance in local health care markets. Individual competitors may suffer not just denial of an insurance payment but actual exclusion from practice, perhaps because various actors, relying upon the peer reviewers' judgment, refuse to deal with them. Although harm to an individual competitor is not itself a harm to competition, competitors who maintain a program capable of excluding other competitors from the market may be in a position to discourage competitive conduct or to exclude enough competitors to create market power. On the other hand, protecting consumers against substandard providers and substandard practice is a valuable social benefit. Indeed, so long as this benefit is achieved only by informing appropriate decision makers, quality-oriented peer review should be viewed favorably under antitrust policy. Unfortunately, its benefits are not easily obtained without running some risk that competition will be impaired.

The primary risk to competition here is again that provider performance will be dictated by professional fiat, denying consumers desirable market options. This hazard of undue standardization does not arise if the peer reviewers limit themselves to retrospective evaluations which identifies true incompetence and simple careless-

ing justices thought that insurers could be trusted to protect consumer interests, that argument assumed a competitive insurance market. *See id.* at 360-61.

94. *See supra* note 70.

ness. Effective quality assurance, however, may require peer reviewers to adopt explicit, prospective standards of acceptable practice.⁹⁵ Such professionally promulgated quality standards, backed by the possibility of exclusion from the market, present a real danger that physicians' clinical methods will be centrally determined, contrary to the premises of the antitrust laws. With such standards in place, doctors' fears of malpractice suits, of action by licensing authorities, of collegial criticism, and of bad publicity push them strongly toward conformity.

Quality-related standards could undoubtedly serve as a vehicle for suppressing responsible innovation in medical practice. For example, a peer-review body might declare substandard certain practices that have not been affirmatively shown to be inferior to accepted methods but that economize enough on physician services to inspire professional opposition. Another possibility is that a professional norm might be entirely valid as a guide to "best" medical practice but should not bind all practitioners, because it makes inadequate allowance for cost considerations or patient preferences. Finally, a medical cartel could employ improper standards or selective enforcement to discipline and discourage particular competitors. For example, if community doctors, disliking HMOs, subjected them and their physicians to unreasonable rules or special scrutiny, HMOs might have to modify their practice style to such an extent that consumers would be deprived of desirable options.⁹⁶ There is enough evidence to cast doubt upon the reliability of professional norms and standards as an exclusive guide to efficient medical practice⁹⁷ that antitrust law's concern about excessive standardization and control of medical practice should be taken seriously.

If it is to tolerate professional quality assurance at all, antitrust law must find ways of preventing the anticompetitive use of the power to label a practitioner as incompetent or neglectful of patient welfare. Issues can perhaps best be structured by analogy to the essential-facilities doctrine. Competitors who collectively control their competitors' access to some resource vital to their survival in the marketplace are held to a degree of accountability for the man-

95. Indeed, the use of written standards may be desirable as a means of ensuring that the program is being administered in an evenhanded, as opposed to an anticompetitive, fashion.

96. See Havighurst & Bovbjerg, *Professional Standards Review Organizations and Health Maintenance Organizations: Are They Compatible?*, 1975 UTAH L. REV. 381, 401-21 (discussing conflicting interests and contrasting styles of medical practice).

97. See *supra* note 65.

ner in which they exercise that power.⁹⁸ Antitrust law, recognizing the procompetitive benefits of the collaboration, does not condemn the concerted action outright but instead insists that the collaborators adopt methods that create no greater threat to competition than is reasonably necessary to achieve those benefits. Although peer reviewers exercise only influence, not control, over the decisions that affect their competitors' welfare, the analogy to the paradigmatic essential-facilities case is clear. The crucial issue is simply how deeply courts should probe in evaluating the collaborators' specific procedures, standards, and actions. The operative legal presumptions, tests, and remedies should not unduly jeopardize the peer reviewers' efficiency-enhancing activities.

As an embodiment of the Rule of Reason, the essential-facilities doctrine leaves considerable room for judgment in assessing a particular collaboration and for tailoring the court's intervention in proportion to the risk of anticompetitive harm.⁹⁹ The case of *Silver v. New York Stock Exchange*¹⁰⁰ is authority for requiring that a powerful, self-regulatory organization adopt fair procedures in administering its standards. Profession-sponsored bodies engaged in quality-oriented peer review should be likewise required to give a

98. See, e.g., *Associated Press v. United States*, 326 U.S. 1, 13 (1945) (dominant news-pooling association of newspapers); *United States v. Terminal R.R. Ass'n*, 224 U.S. 383, 397-98 (1912) (joint railroad control of sole river crossing); *United States v. Realty Multi-List, Inc.*, 629 F.2d 1351, 1355 (5th Cir. 1980) (multiple listing service); *Gamco, Inc. v. Providence Fruit & Produce Bldg., Inc.*, 194 F.2d 484, 486-89 (1st Cir.) (joint control of favorably located warehouse), *cert. denied*, 344 U.S. 817 (1952). Regarding competitor collaboration in research-and-development joint ventures, see DEPARTMENT OF JUSTICE, ANTITRUST GUIDE CONCERNING RESEARCH JOINT VENTURES 21-23 (Nov. 1980) (indicating that a dominant venture, if lawful at all, would not be allowed to exclude competitors arbitrarily). For detailed application of the essential-facilities doctrine to a closely analogous situation—the allocation of hospital staff privileges by a medical staff—see Havighurst, *supra* note 15, at 1111-25.

99. In addition, it serves as a reminder that collective possession, or even exercise, of the power to harm competitors is not in itself an antitrust violation and that procompetitive joint ventures of powerful competitors may be lawful if they are structured and operated in ways that are reasonably compatible with competition. Because profession-sponsored peer-review programs are analogous to such legitimate joint ventures, they should also enjoy the benefit of the doubt when their day-to-day actions are subjected to antitrust review. As legitimate, procompetitive sources of useful information and advice, they should not be placed in jeopardy of paying treble damages for every slip up. As the Supreme Court acknowledged in *Silver v. New York Stock Exchange*, 373 U.S. 341, 360 (1963), a legitimate, competitor-sponsored body in a position to affect the welfare of other competitors must be allowed some "breathing space;" otherwise, the public will be denied the very benefits that justify the body's existence. It is useful to remember, too, that tort law can supply remedies for unfair business conduct that does not threaten the competitive process, making it unnecessary to stretch antitrust law to police simple unfairness.

100. 373 U.S. 341 (1963).

party subject to pending peer-review action notice of the issues, an opportunity to present evidence and counterarguments, and the benefit of an unbiased panel of decision makers.¹⁰¹ A peer-review body that fails to adopt procedures that reduce the danger of biased, anticompetitive actions should be subject, not to per se liability as was called for in the special circumstances of *Silver*,¹⁰² but to close judicial scrutiny. Such scrutiny should entail a full trial on the merits of the action taken with neither special deference to the professional body nor any presumption of its good faith.

If a peer-review program is administered procedurally to minimize potential harms to competition, the level of judicial scrutiny should reflect due recognition by the court of the program's procompetitive, information-generating benefits. Although the peer reviewers' standards are open to substantive evaluation to ensure that they are rationally related to the objective of quality assurance, a court should resist the impulse to go further to make sure that they are the best possible standards or at least substantively good ones. An antitrust courtroom is not the place to resolve such issues.¹⁰³ Precisely because the court cannot define a proper technical standard or even know whether a single standard would be socially desirable, it should refrain from making any such inquiry. It should also not conceive its function as giving affirmative approval to the peer reviewers or their standards. Such a judicial imprimatur could only increase the peer reviewers' credibility (perhaps already excessive) in the eyes of the public and dispel ap-

101. The *Silver* rationale seems to fit the circumstances of both statutory and nonstatutory peer review:

[The] aims of the statutory scheme of self-policing—to protect investors and promote fair dealing—are defeated when an exchange exercises its tremendous economic power without explaining its basis for acting. . . . The requirement of [notice and hearing] will . . . help in effectuating antitrust policies by discouraging anticompetitive applications of exchange rules which are not justifiable as within the scope of the . . . Exchange Act.

Id. at 361-62. The principle invoked is the less-restrictive-alternative requirement. See *supra* note 72. The requirement of an unbiased panel of decision makers is suggested by *Gibson v. Berryhill*, 411 U.S. 564, 578-79 (1973).

102. In *Silver*, the Court found that the defendants, not having employed fair procedures, were guilty of a per se violation and therefore barred from even offering evidence that the plaintiff was a shady operator in fact. *Silver*, 373 U.S. at 364-66. A similar result would be inappropriate in a peer-review case, because peer reviewers do not organize boycotts—as the stock exchange had done in *Silver* in reliance upon a special statute, which the Court found adequate to immunize only actions taken with procedural safeguards. See *supra* notes 36, 101.

103. The Court in *Silver* did not rule on the appropriate standard for reviewing substantive requirements, suggesting that it might be "a standard of arbitrariness, good faith, reasonableness, or some other measure." *Silver*, 373 U.S. at 366.

appropriate skepticism on the part of private decision makers. On balance, even though there is good reason to be concerned over the homogenizing tendencies of peer reviewers' quality standards, it is still difficult to make a case under antitrust law for judicial review that goes beyond ascertaining that such standards have a rational relationship to a procompetitive object.

Like the practice standards they adopt, the peer-reviewers' specific actions in particular cases should also be subjected only to limited scrutiny and upheld if not facially arbitrary or capricious. If the procedures followed were fair and if the standards applied and the record in the case reveal no obvious impropriety, antitrust challenges to such actions should be summarily dismissed. Even plausible allegations of anticompetitive animus should not be sufficient to force a closer look. The recourse of those adversely affected must be to the unrestrained marketplace and to the independent decision makers whose judgments the peer reviewers seek to influence.¹⁰⁴ Indeed, it would be especially useful if courts would justify limited scrutiny in these cases, not by acknowledging their deference to professionals as professionals, but by declaring that competitors in a free market, whose conflict of interests disqualifies them from engaging in coercive self-regulation, are still entitled to combine to publicize their possibly self-interested opinions and to advocate their acceptance.

Undeniably, this legal approach would leave a residual danger of abuse through inappropriate standards or selective enforcement. A peer-review body that systematically harasses a subset of competitors for alleged quality deficiencies could probably, under the limited judicial scrutiny suggested, escape liability for a course of conduct that was anticompetitive in both purpose and effect.¹⁰⁵ This hazard could be addressed, however, by leaving room for pub-

104. To the extent that some competitors are disadvantaged by information and advice published by a peer-review body, incentives are created for them to defend themselves by the various lawful means available in a competitive market. They may lower their prices to attract attention, may publish their contrary views and evidence refuting the charges against them, or may seek legislation recognizing their claims. In general, anything differentiating some competitors from others, even if it does so unfairly, stimulates competitive activity likely to benefit consumers. By the same token, a profession-dominated system that suppresses diversity and controversy may deny consumers desirable options.

105. See *supra* text accompanying note 96. In approving a PSRO's program of private utilization and quality review, the FTC warned the proponents to "avoid any misuse of the peer review program to discriminate against innovative competitors whose practice, though legitimate and appropriate, may pose a competitive threat to other physicians involved in the peer review program." Rhode Island Professional Standards Review Org., 101 F.T.C. 1010, 1011 (1983) (advisory opinion).

lic enforcement agencies to initiate proceedings and to elicit proof of unfair or deceptive standard setting or of systematic discrimination against innovative or overly aggressive competitors. Federal Trade Commission vigilance would seem to be a sufficient protection for the public interest.¹⁰⁶ Although cases brought by a public prosecutor technically stand on the same footing before a court as private suits, it should be easy enough for a court to give the government somewhat greater leeway in making its case in a peer-review challenge than it would give a private party. While doctrinally hard to defend, the suggestion that private suits should be dismissed more readily than public ones should not offend sensibilities once it is conceded that antitrust law is primarily concerned with consumer, not competitor, welfare.

In contrast, the alternative practice of giving private plaintiffs every opportunity to try to prove their inevitable allegations of bias and anticompetitive intent would be fraught with hazard. By raising subjective issues incapable of definitive proof, such an approach would create uncertainties and liability risks that would chill peer-review efforts and the generation of procompetitive information and opinion. For example, physician peer reviewers with strong and sincere views with respect to the dangers of home births would be open to the charge that they were only interested in driving midwives from the market. In such a case, a court would be faced with the choice of either resolving the medical question—one that turns in part on patient preferences and therefore has no definitive medical answer—or verifying the peer reviewers' good faith. But inviting a jury to find bad faith opens the door both to serious unfairness and to findings of good faith that confer more legitimacy upon the peer reviewers than they deserve.¹⁰⁷ Under an antitrust regime that aims to protect competition rather than competitors, the fact that private actors, consulting their own interests, choose to honor the peer reviewers' standards should be viewed as evidence of the peer

106. *See supra* note 105. By informal arrangement with the Department of Justice, the FTC is more likely to take responsibility in this area. Its procedures and expertise equip it to investigate allegations of abuse and selective enforcement. Because its remedies are prospective, respondents face only the costs of defending themselves, not monetary liability.

107. If allegations of bias received a hearing in private quality-assurance cases, physicians singled out for deficiencies would always offer to prove the peer reviewers' anticompetitive animus by showing the failings of other doctors undisciplined by the peer reviewers; opening such issues would have costs far exceeding any benefits. In *Patrick v. Burget*, 800 F.2d 1498 (9th Cir. 1986), a hearing lasting 17 sessions and 60 hours was required to allow a challenged physician to question in turn the quality of care furnished by other doctors in the community. *See* Brief for Appellant at 13.

reviewers' trustworthiness, not as a basis for regulating the source of information and opinion on which others freely rely.¹⁰⁸

There is one type of antitrust case in which evidence of peer reviewers' anticompetitive bias or selective enforcement against a particular physician should probably be received—namely, a case arising under section 2 of the Sherman Act and involving a legitimate allegation of monopolization or an attempt or conspiracy to monopolize.¹⁰⁹ Imposing special burdens directly on a competitor is a generally recognized form of predatory conduct,¹¹⁰ and intent is naturally a central issue in such cases. It is conceivable that a peer-review body might seek, through findings of quality deficiencies, to exclude enough competitors to allow the remaining few to exercise market power. For example, a single, dominant group practice in a community might dominate the peer-review process so as to obtain a monopoly by scrutinizing competing physicians so closely that they would either find their market opportunities foreclosed or choose to practice elsewhere. (Indeed, such a scenario is the essence of the allegations in *Patrick v. Burget*, a much heralded case arising in Astoria, Oregon.¹¹¹) Because a dangerous probability of actual

108. Great de facto influence wielded by a professional body is sometimes thought to justify closer judicial scrutiny. *E.g.*, *Majorie Webster Jr. College v. Middle States Ass'n of Colleges and Secondary Schools, Inc.*, 432 F.2d 650 (D.C. Cir.), *cert. denied*, 400 U.S. 965 (1970) (common-law case discussed in Havighurst & King, *supra* note 26, at 164-66). There is reason to believe, however, that private users of information and opinion will reject biased advice, thus providing protection against the apprehended abuses. *See generally* Havighurst & King, *supra* note 26, at 189-201.

109. 15 U.S.C. § 2 (1982). *See generally* E. GELLHORN, *supra* note 11, at 112-39.

110. Abuse of duly constituted legal process may be a basis for a monopolization charge. *See, e.g.*, *California Motor Transport Co. v. Trucking Unlimited*, 404 U.S. 508 (1972), discussed *supra* note 42. *See also* Krattenmaker & Salop, *Anticompetitive Exclusion: Raising Rivals' Costs to Achieve Power over Price* (in press, 96 YALE L.J.).

111. *Patrick v. Burget*, 800 F.2d 1498 (9th Cir. 1986). The plaintiff, who won a large judgment in the trial court, was one of the few doctors in Astoria who was not a member of the Astoria Clinic, and his exclusion might be regarded as an appropriate concern of an antitrust court. The court of appeals remanded the case for further attention to the issues surrounding the monopolization issues in the case. *Id.* at 1509.

The trial court result in this case has attracted a great deal of attention. *See, e.g.*, Dolin, *supra* note 1; Rust, *supra* note 3; Holoweiko, *What Competition Can Do To Peer Review*, *Med. Econ.*, Aug. 19, 1985, at 122. It also helped to trigger political concern that the entire peer-review enterprise may be jeopardized by antitrust threats. *See infra* text accompanying notes 132-36. This concern was somewhat misplaced, however, because the case involved an unusual market and a potential monopolistic situation, not usually found in such cases, that may have required close antitrust scrutiny. The case could have been best handled by ensuring that the hospital, rather than its doctors, was the ultimate arbiter of Dr. Patrick's right to practice. *See generally* Havighurst, *supra* note 15, at 1116-22, 1125-39. This would have meant dismissing the case because Patrick sued before the hospital ever had a chance to act on his privileges. Unfortunately, the court of appeals reversed the trial court on a more controversial ground. *See infra* note 136.

monopoly over the delivery of services would have to be shown in such cases, few of them are likely to arise. In any event, they raise concerns quite distinct from those in cases challenging peer-review efforts only as concerted action under section 1.

Despite the possibility that peer review will occasionally be less than evenhanded and will burden some competitors unfairly, the best policy for antitrust courts to follow in nonmonopolization cases is to limit their scrutiny of properly conducted peer-review activities. If the peer reviewers are biased in fact, independent decision makers will soon learn not to trust them and will look elsewhere for guidance. This is the result most in keeping with the open competitive process that antitrust law seeks to foster. The alternative of judicially regulating, and thus inhibiting, the generation of information in a chronically information-poor market should seem a distinctly poorer policy.

VII. COMBATting MONOPOLY IN THE MARKET FOR INFORMATION

Unstated so far in this analysis of the antitrust status of professional peer review is a premise that, once elaborated, should alleviate residual concerns over the great influence exercised by some professional peer-review bodies. Some observers will no doubt fear that a laissez-faire policy, such as that recommended above, will open the door to continued professional dominance and exclusion from the marketplace of innovative or aggressively competitive providers. Nevertheless, once the true source of such concerns is identified, it is possible to suggest some further antitrust remedies that, by addressing the root cause of the problem rather than its symptoms, justify leaving properly run peer-review bodies free to conduct their day-to-day business without undue legal risks. The discussion here completes the picture of an antitrust regime that both encourages the production of authoritative information and opinion and preserves market opportunities for those providers who may be at odds with majoritarian professional interests.¹¹²

The key to the antitrust analysis here is a shift in focus away from competition in markets for health services to another "relevant market" altogether—namely, the market for information and opinion useful to those purchasing a particular type of health care

112. The analysis is similar to that presented at greater length in Havighurst & King, *supra* note 26, at 264-325.

or otherwise interested in its quality, appropriateness, and price.¹¹³ From all that has been said above, it should be obvious how important it is that such information and opinion—often involving highly debatable and complex technical and value-laden issues—be produced under competitive rather than monopolistic conditions. It is desirable from a policy standpoint that such information and opinion be treated as articles of “trade or commerce” within the meaning of the Sherman Act; competition in their production could thus be directly protected against monopolization and restraint. The legal arguments which can be offered in support of such “relevant markets” have been stated in another place¹¹⁴ and will not be repeated here. It is possible, however, in concluding this Article to suggest briefly how attending to the state of competition in the market for such information and opinion can alleviate any fears about allowing profession-sponsored peer-review bodies to opine freely—subject only to the limitations outlined above—regarding professional fees, the utilization of services, and the quality of care rendered by individual providers.

The crucial points are: (1) that those interested in the answers to difficult questions should be free to seek them from other sources, and (2) that those with different ideas should be free to express them. If professional bodies sponsoring peer-review efforts do nothing to monopolize the giving of advice or to restrain independent parties from gathering data and acting upon their own impressions and judgments, the competitive process remains operative and unrestrained. By analogy to section 2 of the Sherman Act, which prohibits monopolizing conduct but not a monopoly that is gained by superior performance, it is of no legal consequence that a single lawful entity is the sole formal peer-review mechanism existing in an area or that it exercises extraordinary influence over the choices made by others. The important thing is that entry into the business of advising purchasers of health care is not blocked by concerted action and that the relevant decision makers are free to seek their own counsel and to make their own choices.

These conditions of freedom of entry and action have not always been satisfied in the health care marketplace. Indeed, history reveals several illuminating instances of coerced acceptance by health insurers of profession-sponsored peer review. For example, in the early 1970's, Aetna Life and Casualty Company undertook to

113. See *supra* note 89.

114. See Havighurst & King, *supra* note 48, at 299-300.

help its insureds resist lawsuits brought by physicians to recover fees that the insurer regarded as excessive. Concerted professional resistance to this practice included an AMA resolution disapproving it and opining that insurers should develop their reimbursement policies only in consultation with organized medicine. As a result of the outcry, Aetna met with AMA representatives and adopted the following new policies:

3. When, following discussion with the physician, Aetna is unable to accept the full amount of a charge as within the range of prevailing fees, it will ordinarily seek the advice of a peer review committee or other review mechanism of the appropriate medical society before finally determining its benefit payment
4. In any instance involving a question of types of treatments, alternative types of services, or volume of services ordered or provided, it is the policy of Aetna to make inquiry of the physician first and, if necessary, to seek supplemental advice through peer review¹¹⁵

Many of the acts by which Aetna was coerced to accept professional peer review appear to have constituted antitrust violations.¹¹⁶ Evidence of similar efforts to force large purchasers to employ only professionally approved cost-containment techniques also appeared in recent antitrust cases involving Michigan physicians¹¹⁷ and Indiana dentists.¹¹⁸

These experiences lend credence to the argument that prohibiting exclusionary practices that foster monopoly in markets for consumer-oriented technical information and opinion would leave those markets competitive and open enough to allow profession-sponsored peer review to function without close judicial oversight.¹¹⁹ Although antitrust law has frequently been employed to

115. Goldberg & Greenberg, *supra* note 55, at 64-65.

116. Although boycotts are unlawful per se (*supra* note 36), an alternative way of viewing these professional efforts would be as conduct aimed at monopolizing the provision of information and opinion.

117. See *In re Michigan State Med. Soc'y*, 101 F.T.C. 191, 267-75 (1983) (medical society pressure on third-party payors regarding amount and manner of physician reimbursement).

118. See *In re Indiana Fed'n of Dentists*, 101 F.T.C. 57, 102-06 (1983) (order prohibiting dentists from organizing to restrict cooperation with third-party payor), *vacated*, 745 F.2d 1124 (7th Cir. 1984), *rev'd*, F.T.C. v. Indiana Fed'n of Dentists, 106 S. Ct. 2009 (1986); see also *In re Texas Dental Ass'n*, 100 F.T.C. 536, 538 (1982) (complaint leading to consent order).

119. Decisions concerning first amendment issues have emphasized the consuming public's interest in receiving information from more than one source. See *supra* note 44. Indeed, the Supreme Court has permitted regulation limiting broadcasters' freedom in order to promote diversity in information sources. In *Red Lion Broadcasting Co. v. FCC*, 395 U.S. 367 (1969), the Court noted that "it is the purpose of the First Amendment to preserve an uninhibited marketplace of ideas in which truth will ultimately prevail, rather than to counte-

regulate the conduct of firms occupying powerful market positions, it is gradually being appreciated that antitrust attacks are more appropriately focused on maintaining competitive market conditions so that private decision makers may operate without close regulatory supervision.¹²⁰ It seems entirely in keeping with sound antitrust policy for professional peer review that focuses on advice giving and contributes to an open public debate over proper standards in medical care to be spared significant antitrust risks. Only programs that are part of a professional effort to dominate the field and to exercise control rather than influence should face serious difficulty in the antitrust courts.

VIII. IMMUNITIES AND EXEMPTIONS FOR PEER REVIEWERS

The medical profession's fears of antitrust and other lawsuits by practitioners injured by professional peer review has recently prompted a series of new legislative proposals to shelter peer reviewers from litigation. Many of these measures have been offered as a partial response to the alleged crisis in medical malpractice insurance, on the assumption that strengthening professional peer review would bring about needed improvements in the quality of care. As this Article was being put into final form, Congress passed, and the President signed, the Health Care Quality Improvement Act of 1986 (HCQIA).¹²¹ One purpose of this act is to combat "the threat of private money damage liability under Federal laws, including treble damage liability under Federal antitrust law, [which] unrea-

nance monopolization of that market It is the right of the public to receive suitable access to . . . ideas . . . which is crucial" *Id.* at 390. The use of antitrust law to promote diversity in the provision of information and advice concerning health services would seem beneficial to consumers.

120. *See, e.g.,* *Copperweld Corp. v. Independence Tube Corp.*, 467 U.S. 752 (1984). A parent corporation and its wholly-owned subsidiary were held not to be subject to suit under § 1 for conspiring with each other. The Court's opinion underscores the importance in antitrust analysis of identifying legitimate decision-making entities, which can be closely scrutinized only at the time of their formation or under the § 2 prohibition of monopolization. *See id.* at 777. Such lawful entities should be protected thereafter against antitrust challenges to their day-to-day business activities. The Court stated that the vice of concerted action is that it "deprives the marketplace of the independent centers of decisionmaking that competition assumes and demands." *Id.* at 769. Observing that the exemption of single entities from scrutiny under § 1 leaves a "'gap' in the Act's proscription against unreasonable restraint[s]," the Court said, "Congress left this 'gap' for eminently sound reasons. Subjecting a single firm's every action to judicial scrutiny for reasonableness would threaten to discourage the competitive enthusiasm that the antitrust laws seek to promote." *Id.* at 775. The analysis in this Article extends this reasoning to provide a measure of comparable protection for procompetitive joint action by physicians.

121. Pub. L. No. 99-660, §§ 401-32, __ Stat. __ (1986).

sonably discourages physicians from participating in effective professional peer review."¹²²

The approach to antitrust immunity taken in the HCQIA is unusual. The act leaves untouched the antitrust statutes as well as all other legal doctrines under which an aggrieved physician might sue. It proceeds instead by erecting special barriers to the bringing of private suits for money damages under both federal law (other than the civil rights acts) and state law (unless a state acts to reinstate its remedies).¹²³ Because the statute does not change antitrust law as such, it does not directly affect the analysis in this Article. Nevertheless, the new hurdles that a plaintiff must now clear before getting to the antitrust merits in a peer-review case must be briefly outlined to determine whether Congress may have gone too far in sheltering conduct that may sometimes be harmful to the competitive process. It does not appear that Congress has done anything in the HCQIA that significantly undermines the conceptual and legal formulations provided herein.

Under the act, a plaintiff challenging a "professional review action" by a "professional review body," including a hospital, an alternative delivery system such as an HMO, or a professional society, confronts a statutory presumption of reasonableness and procedural regularity. Unless that presumption is rebutted by "a preponderance of the evidence,"¹²⁴ everyone participating in or assisting in the action qualifies for statutory immunity. Because there are numerous factual issues that can be raised by a plaintiff to contest immunity, however, the new act does more to complicate than to simplify litigation in this area. Nevertheless, the approach chosen may serve to deter some lawsuits. Not only may some prospective plaintiffs be daunted by the additional burdens of proof they must bear, but the statute raises the plaintiff's stakes in the litigation by a fee-shifting provision. Under this provision, the plaintiff will be liable for a defendant's reasonable legal costs if the court finds that his claim was "frivolous, unreasonable, without foundation, or in bad faith."¹²⁵ These provisions make it both harder for a plaintiff to prevail and potentially more costly to lose. If it is true,

122. *Id.* at § 402(4). The act also provides for a central clearinghouse to receive and make available to designated persons reports of actions adversely affecting individual physicians' hospital privileges, of payments made in settling malpractice claims, and of disciplinary actions taken by state licensing boards. *Id.* at §§ 421-27.

123. It preserves the power of state attorneys general, acting as *parens patriae*, to bring damage actions under § 4C of the Clayton Act, 15 U.S.C. § 15C (1982).

124. Section 412(a).

125. Section 413.

as some believe, that physicians sometimes challenge unfavorable peer-review actions with little hope of winning but for vindictive purposes or in order to gain a strategic advantage for further negotiations, then these provisions may have the desired effect of fostering oversight of practitioners by their professional peers.

For present purposes, it is notable that the new legislation has no bearing on peer review of fees or utilization for cost-containment purposes, extending its immunity only to actions taken "in the reasonable belief that the action was in furtherance of quality health care."¹²⁶ The main focus of the act is on physician self-scrutiny that occurs in hospitals, in medical group practices, and in medical societies, contexts that are distinguishable from the community-wide, information-giving peer-review bodies that are the main focus of this Article. Nevertheless, the statute defines a "health care entity" in such a way that a PRO or other free-standing, advisory peer-review body could qualify for immunity under it when engaged in quality-oriented peer review.¹²⁷

Perhaps the greatest flaw in the HCQIA is its failure fully to observe and preserve the distinction, stressed in this Article, between purely advisory peer review and peer review that is coupled with sanctions. Thus, a hospital medical staff that has effectively seized authority over clinical privileges from the governing board¹²⁸ and a dominant medical society that prescribes and enforces standards of conduct for its members¹²⁹ can qualify for antitrust immunity under the statute's terms. To protect against possible abuses, however, the act specifies that immunity attaches only to actions that are "based on the competence and professional conduct of an individual physician (which conduct affects (or may affect) adversely the health or welfare of a patient or patients)."¹³⁰ Moreover, it goes on to specify further that immunity does not extend to actions disciplining a physician for certain affiliations or associations, for advertising, for price cutting or other competitive acts, or for relationships with other types of health care personnel.¹³¹ It

126. Section 412(a)(1).

127. Section 431(4)(A)(iii).

128. See generally Havighurst, *supra* note 15.

129. See *supra* note 26; *infra* note 131.

130. Section 431(9).

131. Section 431(9). These provisions were apparently inserted at the insistence of the FTC. Whether they block all opportunities for abuse is an interesting question. For example, could a medical society, invoking quality-of-care concerns, expel a member for "unethically" cooperating with a health insurer's requirement that X-rays or other documentation be submitted in advance to justify a patient's elective hospitalization? Cf. *FTC v. Indiana Fed'n of*

would appear that these provisions create some new opportunities for litigating at length the true motives of the peer reviewers. Because many potential plaintiffs may perceive that the actions against them fall within these exceptions, the threat of lawsuits may not be reduced as much as the sponsors of the bill hoped.

An initial question raised by the HCQIA is whether legislative protection of peer reviewers against antitrust and other lawsuits was really necessary. Statutes already in place provided some immunity for peer reviewers. Thus, the legislation establishing PROs confers immunity from criminal and civil liability on individuals carrying out PRO activities and those providing information to PROs; the PRO itself is not exempted, however, nor is any sponsoring organization.¹³² State statutes also frequently provide protections to peer-review participants,¹³³ but these statutes have been construed not to displace federal antitrust oversight.¹³⁴ Although two states' authorization and supervision of hospital-based peer review have been deemed sufficient to support a state-action exemption from the antitrust laws,¹³⁵ these holdings promise little relief because, in addition to being unconvincing, they do not extend automatically to other states.¹³⁶

Dentists, 106 S. Ct. 2009 (1986) (condemning dental society's agreement to similar effect). The issue would appear to turn on whether the society's action amounts to condemning "competitive acts intended to solicit or retain business." Consider also whether a medical society could decide that providing a new, untested medical service was unethical and inconsistent with good-quality care. *Cf. Vest v. Waring*, 565 F. Supp. 674 (N.D. Ga. 1983) (society challenged for questioning ethics of radial keratotomy, an innovative and profitable, but unproven treatment for nearsightedness); *Schaschar v. American Acad. of Ophthalmology, Inc.*, 1985-2 Trade Cas. (CCH) ¶ 66,681 (N.D. Ill. 1985) (similar).

132. 42 U.S.C. § 1320c-6(a) (1982).

133. *E.g.*, CAL. CIV. CODE § 43.7 (West 1982) (immunizing individuals engaged in peer review, but not the sponsoring professional societies or hospitals, from monetary liability); FLA. STAT. ANN. § 768.40(3)(a) (West 1986) (immunizing members of "medical review committees"); ILL. ANN. STAT. ch. 111 1/2 § 151.2 (Smith-Hurd Supp. 1986) (immunizing hospitals and their staffs).

134. *Memorial Hosp. of McHenry County v. Shadur*, 664 F.2d 1058, 1063 (7th Cir. 1981) (construing a state law restricting the discoverability of peer-review records, the court said "The public interest in private enforcement of federal antitrust law in this context is simply too strong to permit the exclusion of relevant and possibly crucial evidence by application of the Hospital's privilege.").

If state laws hamper plaintiffs seeking to bring tort actions for defamation, unfair competition, or interference with contractual relations but do not affect federal antitrust actions, claims of the latter type become more likely, strengthening the argument for federal action to relieve pressure on peer reviewers.

135. *See Patrick v. Burget*, 800 F.2d 1498 (9th Cir. 1986); *Marrese v. Interqual, Inc.*, 748 F.2d 373 (7th Cir. 1984), *cert. denied*, 105 S. Ct. 3501 (1985).

136. For a persuasive critique of the ruling on the Indiana legislation, see Brief of the FTC as Amicus Curiae, *Lombardo v. Our Lady of Mercy Hosp.*, No. 85-2474 (7th Cir.

The threat of antitrust actions against peer reviewers thus appears inadequately controlled by pre-HCQIA legislation. Moreover, state law preclusion of suits under common-law theories may have caused federal antitrust suits to become even more popular in recent years. In addition, the prospect of recovering treble damages and attorneys' fees and the plaintiff's probable belief that he is the victim of an anticompetitive conspiracy have also added to the attractiveness of antitrust actions by disadvantaged practitioners. In fact, many suits have been filed, and many more have probably been threatened.

A more fundamental question would appear to be the validity of the HCQIA's apparent premise that antitrust law itself supplies inadequate deterrence to these suits. One serious problem is that defense costs are high, even if the suit is eventually won. Antitrust actions in this area have most often been handled in ways that allow many motions, extensive discovery, and lengthy trials. Most cases involve multiple parties, each of whom requires independent counsel. In addition, physicians' liability and defense costs may not be covered by their malpractice insurance. Because plaintiffs know of these burdens and may therefore be tempted to bring suits for strategic or vexatious purposes, it may be irrelevant that peer reviewers' risk of actual liability in these cases is small. Recognition of the high cost of defending against these challenges could easily inhibit peer-review actions that would be in the best interest of consumers. Such dilemmas are common in a legal system that, in addition to being highly unpredictable, forces parties to bear their own litigation costs, win or lose. A strong argument could therefore be made for more extensive, even automatic, fee shifting instead of the conditional fee shifting provided for in the HCQIA.

Although it may seem desirable to reduce the ability of marginal practitioners to retaliate for legitimate actions taken against them, the other horn of the legal system's dilemma is the risk that abusive conduct will be inadequately policed if statutory immunities reduce the threat of suit. The HCQIA's solution to this dilemma is not to grant a complete exemption but to specify the conditions that must

1985). In *Patrick v. Burget*, 800 F.2d 1498 (9th Cir. 1986), the court read the state law as expressing a state policy inconsistent with federal law. But the state had done nothing more than require hospitals to control access to their medical staffs. Although antitrust law may require hospitals not to let their medical staffs exclude competitors for their own reasons (*see Havighurst, supra* note 15), it would generally support hospital policing of the quality of care provided. There was no reason to think the state had any different policy or had provided (as the state-action doctrine requires) supervision protective of consumers against anticompetitive abuses.

be satisfied before the exemption may be invoked. Although hard to criticize substantively, this approach may make litigation even more complicated and costly and may in addition do a disservice to antitrust law by implying that the courts employing traditional doctrine are incapable of reaching sound results in these cases on their own; indeed, it may confirm the misinterpretations of the antitrust statutes, criticized above, that stand in opposition to useful collective action. Because antitrust doctrine itself remains unaffected by the new law, there is still a need for courts to shape that doctrine so that entities that merely provide information to independent decisionmakers and entities that stand in a truly vertical relationship to the plaintiff can have antitrust claims against them summarily dismissed without reference to the HCQIA. It would be ironic indeed if the solution to the problem of vexatious and burdensome litigation against professional peer review were ultimately to be found in antitrust principles themselves and not in the legislation that Congress devised specifically for the purpose.

The thesis of this Article is that the antitrust laws can readily be interpreted and administered to encourage procompetitive concerted action while prohibiting peer-review programs that are structured or operated in ways truly incompatible with competition. If the legal interpretations offered here were accepted and if peer reviewers tailored their conduct accordingly, courts could summarily dismiss most antitrust suits brought against professional bodies engaged in peer review. The wisest congressional policy, therefore, would have been simply to encourage antitrust courts to limit their role to protecting the competitive process, rejecting the task of vindicating the supposed rights of competitors who claim to have been hurt in that process. Unfortunately, the HCQIA fails to set antitrust doctrine straight, leaving the courts to learn for themselves that their task is not to provide judicial review of peer-review actions but rather to make certain that the peer reviewers work within, and do not displace, the decentralized, vigorously competitive system contemplated by antitrust policy.

IX. AN OVERVIEW OF THE DOCTRINAL ISSUES

The status of medical peer review under the federal antitrust laws is important not only because it directly affects the nature and aggressiveness of professional cost-containment and quality-assurance efforts, but also because it expresses in operational terms society's expectations of the organized medical profession. The conclusion from the analysis in this Article is that profession-spon-

sored peer reviewers should have an effective antitrust defense if they confine themselves to defining norms, setting standards, and making findings of compliance or noncompliance with those norms and standards in particular cases. The crucial requirement is that they act only in an advisory and not in a regulatory capacity, leaving to others the decision whether to comply with the peer reviewers' recommendations or to act upon the peer reviewers' determinations of compliance or noncompliance.

Under the principles developed here, when a plaintiff complains of the actions of a profession-sponsored peer-review body an antitrust court should limit itself to ascertaining two things: (1) whether the peer-review effort was indeed procompetitive in its essential features, and (2) whether the peer reviewers had a rational basis related to their procompetitive mission for acting as they did in the plaintiff's case. Such limited scrutiny can be exercised by the court without a full trial investigating the plaintiff's performance and the defendants' motives and behavior. Under this view of peer-review activities, most cases against peer reviewers could be summarily dismissed. If responsible professional groups can thus be spared the risk of heavy litigation burdens, peer reviewers should be able and willing to take actions in marginal cases that they are currently reluctant to take. The public should ultimately benefit from more aggressive peer review.

The legal conclusions reached here reflect both a recognition of the procompetitive features of professional peer review and a rigorous insistence that peer review, properly conducted in a nonregulatory spirit, involves no restraint of trade even though it may adversely affect some competitors. In an area such as health care, where consumers lack good information and must rely upon lay or professional intermediaries to help them make decisions, it is useful for the medical profession, biased though it may be toward overvaluing its own norms and the services of its members, to make its advice and standards publicly available. As long as consumers and others are free to make as much or as little use of such advice and standards as they choose, the competitive process continues to operate effectively. In such a competitive setting, the profession will have an incentive to maintain its credibility by offering good advice. Although the law now prevents physicians from exercising the collective control they once had over the provision and pricing of medical care, the medical profession can still speak for an honorable tradition and important values. Consumers will benefit from both the profession's authoritative guidance and their own freedom to

reject that guidance when cost considerations or their own perceptions, preferences, or tastes incline them in a different direction.

The alternative to the style of antitrust analysis proposed here for professional peer-review programs is a vague, motive-oriented inquiry that seeks to ensure in each case that it was public and not private interests that were being served.¹³⁷ This approach, which is similar to that employed in reviewing the work of public regulatory bodies, generally muddies more than it clarifies. In particular, it makes little distinction between harm to competitors and harm to competition or between programs that give advice to independent, noncolluding decision makers and programs that seek to enforce their own judgments directly by organizing coercive boycotts or excluding nonconformists from valuable benefits and privileges. Under motive-based approaches, the actions of the peer reviewers are both attacked and defended using both "reasonableness" and the general public interest as the operative standards.¹³⁸ These tests bear little resemblance, however, to the Rule of Reason, which should focus exclusively on identifying net harm to competition and should reject worthy-purpose defenses when such harm is found. Fortunately, the essential-facilities doctrine offers helpful guidance in structuring the inquiry in accordance with the Rule of Reason, thus avoiding the implicit equation of professional bodies with public regulatory agencies.

X. CONCLUSION

This Article is the third in a series of efforts to evaluate traditional forms of concerted action by medical and other professionals in the light of antitrust theory. Here, as in the earlier studies of private accrediting and credentialing programs¹³⁹ and of hospital medical staffs,¹⁴⁰ the conclusion reached is that the collective efforts of professionals to provide technical advice and assistance to other

137. An exponent of this approach is Professor Kissam, who has recommended it in a variety of contexts. See Kissam, Webber, Bigus & Holzgraefe, *Antitrust and Hospital Privileges: Testing the Conventional Wisdom*, 70 CALIF. L. REV. 595 (1982); Kissam, *Government Policy Toward Medical Accreditation and Certification: The Antitrust Laws and Other Procompetitive Strategies*, 1983 WIS. L. REV. 1. Courts in staff privilege cases have found the Kissam test to their liking. E.g., *Robinson v. Magovern*, 521 F. Supp. 842 (W.D. Pa. 1981); *Hackett v. Metropolitan Gen. Hosp.*, 1982-83 Trade Cos. (CCH) — 65, 059 (Fla. Dist. Ct. App. 1982). See the critique of this approach in Havighurst, *supra* note 15, at 1109-11, 1136-39.

138. See *supra* text accompanying notes 37-47.

139. See Havighurst & King, *supra* note 48.

140. See Havighurst, *supra* note 15.

participants in the health care marketplace are fundamentally procompetitive and should therefore be viewed favorably by antitrust courts. With a proper appreciation of how such collective action can make information-poor markets function more efficiently, there is no need for antitrust exemptions or for special antitrust rules to facilitate these useful professional activities. Instead, it is only necessary to apply antitrust law in an enlightened fashion, focusing on the benefits of information and advice to the competitive process rather than on the impact of a certain action on specific competitors. With this focus, it is of no special moment that a particular professional body influences independent decision makers to prefer, or to avoid, a particular health care provider. Antitrust courts should be actively concerned only when professional bodies go beyond merely advising others and give direct effect to their judgments by taking coercive action against deviating providers or by inviting physicians collusively to abide by collective standards. Actions aimed at monopolizing either the provision of particular services or the business of setting and applying standards may also occasionally be appropriate targets for antitrust action.

The views presented here have one important implication for practitioners engaged in collective professional endeavors. Despite their good intentions, even the most conscientious professionals may face real antitrust dangers if they cling to traditional perceptions of their function in the health care marketplace. The antiquated idea that professionals are entitled to regulate themselves—that is, actually control through agreements and coercive sanctions the conduct of individual practitioners—must give way to a recognition that professional groups are expected by society to confine themselves to being advocates before, and expert advisors to, independent public and private entities, which are the only legitimate final decision makers in the health care sector. Although it will be difficult for professionals to surrender their traditional powers, the profession's new role is a respectable and important one. In the American system, no single interest group should dominate a particular field of endeavor. Nevertheless, in a field so fraught with uncertainty as health care, the American people are likely to place continued faith in pronouncements of the medical community. It is the duty of the medical profession, advocating its views in the open marketplace of public opinion and ideas, not to abuse that public trust. As long as consumers and those who act on their behalf remain free to accept or reject the authoritative advice thus offered,

professionalism and competition can easily and productively coexist.